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"Products conceived and developed by nurses & other healthcare professionals"

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17229 Lemon St.-Ste. # E7 Hesperia, CA.92345
(800) 6760462 (760) 9497707 FAX (760) 948-1916

Response to Petition & Request for Information

To whom it may concern:

Attn: Kenya

Re: Patent No. 6,381,787 Infant positioning device

I am enclosing what we spoke about, the PTO 96. And, I have included a letter to explain the chain of attorneys as well as an explanation for the chain of events that led to our unavoidable delay and statements from the personnel that had first-hand knowledge of the circumstances surrounding the failure to pay the maintenance fees. And, a copy of the petition and other forms already sent. The change of address has already been filed, but would prefer that you use the above address for communications concerning this matter if possible.

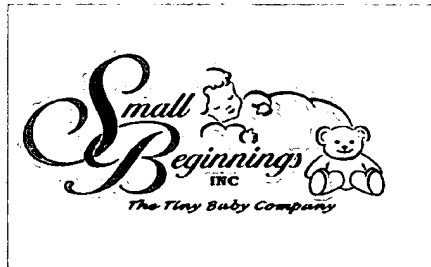
With highest hopes;

M. Sharon Rogone RNC-E, CEO
Small Beginnings Inc.
17229 #E7 Lemon St.
Hesperia, CA 92345
760-949-7707
Fax 760-948-1916
www.small-beginnings.com

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To whom it may concern:

We are considered a micro-small business and woman owned. I have been a neonatal specialty nurse and started this business about 20 years ago. I am filling this petition to reinstate the following patent with all the documents and letters and evidence for the reasons for unavoidable delay of payment.

Infant positioning device	"Preemie Nest"	Appl. No.: 09500736	Patent No.: 6381787
Rogone	Dated: May 7, 2002	Exp: 2006	Total Fees: \$ 2430.00

I wear many caps in my business and I am only an expert when it comes to the care of the babies. My husband, a respiratory therapist and PA, is responsible for sales and distributors, both domestic and abroad. My COO, Kenneth S. Croteau, RRT and BA of Business, handled most of our business affairs, contracts, business licenses, fees, corporate affairs, etc.. We were all trying to ensure that our fast growing small business was keeping up with all FDA and international requirements, as well as good manufacturing practices, patents, trademarks, copyrights, etc. We were all trying to ascertain that all aspects of the business were following all required guidelines. I picked up all financials and wrote and handled most of the patents and the web site and everything else that is not covered. That was and did, constitute our entire administrative staff, but since Ken's death we have had to add more help.

Let me explain the time line on our attorney's of record, because this paperwork and the letter was so lengthy I tried to minimize the explanation, however since all is not clear I will elaborate. Mr. Ted Lopez was not my first attorney. The first attorney was the one named on the above cited patent, the firm of Kristi, Parker and Hale. They finished that first patent for me. I then hired another attorney firm, Skjerven, Morrill & MacPhearson/Lopez, because Ted, a dear friend, went to work for them. They took me to the cleaners and then did nothing. There was a class action suit against that firm, which broke up, and our fees were reduced but were still high, they sent us no notices they received. Mr. Lopez, Ted, was a new attorney and he had graduated with degrees in engineering and law. He was just starting and was unaware of the law firm's practices. He quit their firm and then tried to help me. We had gotten a notice from Hale and Ted took over the patents. He knew that I was behind the eight ball and my hands were full, and I trusted him completely, so I paid whatever he said was owed. I believe that was in late 2004. Shortly after I hired a COO, Kenneth (Ken) Croteau, and Ted informed us of all that he had done and what would need to be taken care of in the future regarding our patents and fees. He then went on to pursued his law career (although he still does some work for us). I put everything on our master calendar, and I thought I had everything covered. Funds have always been an issue with my small business and sometimes we had to

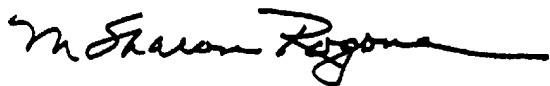
put off some payments until the last minute, often robbing Peter to pay Paul. It has always been a balancing act. I was never able to get a SBA loan or any other than a \$100K line of credit. This did not give me a very big margin to work with, but I did it. The 3 of us were growing our small company and wearing many hats, but I was sure we were covered. **Then all the calamities hit.**

There have been a series of terrible and overwhelming occurrences that have plagued our very small company from early 2005 to late 2010. I am the CEO of my small company and the responsible party for all. The buck stops here. Well, I fell at the first of the year, 2005, and I injured my back (fees are due?). Then in horrible pain I began an ordeal of doctors, pain medication, referrals, appointments and a botched surgery in Aug. of 2005. (fees are due?) This surgery caused my back to collapse and I shrunk 3 inches in height and the pain was unbearable. I could hardly stand or sit up. Again I began another ordeal of, fighting with the HMO, (fees were due?) finding a different doctor, and finally, a surgery at Cedars Sinai Los Angeles in Dec. of 2007, to rebuild my back. But, after the surgery and after all the trauma to my spine, there was damage to the nerves in my left leg and it was paralyzed and had unrelenting excruciating pain, then rehab and physical therapy to try for a recovery. I still have nerve damage to that leg with atrophy of the femoral muscles and constant irritating and strange pain, but I can sit and stand and walk with minimal pain. During that time I had to take serious pain medication to tolerate anything, which made me sleepy, tired, and unable to concentrate well, which hindered all my work. When finally I was able to function again I returned full time to work at the end of 2009. When I returned I had to pick up all the pieces and start to figure out all that was missing in my absence because meanwhile Ken was going through his own ordeal and he is my back up and my right hand man. FDA, CPSC, Good manufacturing practices, USPTO, corporate filings, business licenses, patents, etc, it was all a bit overwhelming to try to pick up what had been neglected. Ken, my COO, and dear friend, and an integral part of my business, and my backup during my illness and absence, had his own problems. A series of illnesses plagued his family and he, himself from 2007-2010, that pulled him from the office much of the time. He hospiced his brother-in-law who was dying of melanoma cancer in early 2006. I am out (fees were due?) and Ken is trying to do his job and pick up my duties as well. Things were missed, and in addition, his father-in-law and mother-in-law died during this same time as well. After his brother-in-laws' death in late 2007 (fees were due?) Ken began to behave differently. He was forgetting conversations and missing important points that we had all agreed needed to be in our contracts, and he could not even let me know what had been done or not done. He began to miss work more and more and then one day he showed up at the office stumbling and very disoriented and unstable. My husband and I immediately rushed him to the hospital where he was finally diagnosed with viral meningitis and could not function at all, so we had to start trying to absorb his part of the business as well as our own. Ken had just started coming back part time following his bout with meningitis when it was discovered he had a 90% blockage of his main stem coronary artery, this meant more time out of the office. We are very small, a micro business and it requires all of us to make sure it runs effectively. (fees are due?) One missing is very devastating. Ken was finally well enough to begin returning to work in late 2009 and to begin trying to catch up with everything. Then one morning soon after his return he approached my husband and indicated he was urinating blood. My husband, who is also a physician assistant, indicated he needed to see an urologist ASAP. He was diagnosed with a cancerous tumor on his kidney in early 2010. They remove the tumor and the kidney but it had metastasized. It was very aggressive and destructive, and ravaged our dear friend. After about 24-25 blood transfusions and chemo and constant pain, 10 months later, Ken succumbed to the cancer and passed in December of 2010. He was only 57 years old and a major portion of my small business and we are still trying to recover from his loss. So as I pick up all the pieces, still more tragedy, during this same time, my brother passed in 2008 and then my mother had a stroke in April of 2009 and we kept her at home and hospiced her. She became more and more disoriented as time went by. My father was helping care for her so I could go to work, but he was

fast approaching 90 and then three days before Christmas 12/22/2009 my father passed away in his sleep. I barely took a breath and four days later 12/26/2009, my mother passed. It has been very unbelievable and an almost unbearably difficult time in our lives. Late in 2009 we hired our executive assistant to take over some of Ken's responsibility. In going through his things to get her up to speed we came upon the master calendar he had hidden away among his massive pile of unfiled paperwork during my illness. This was early in 2010 and this is when we discovered the patent fiasco and the fact that the change of address forms were never filed, we received no notices, our error and my patents had expired. So I started immediately researching and making calls. After many calls I finally spoke to Customer Service and after much to do and several days I made contact with Inventors Assistance, they referred me to Petitions which was more delays but finally I was able to researched the forms they told me I needed and tried to take care of the change of address forms and the PTO 65. I then called the petitions office again for help to fill everything out correctly and I am appreciative of their help. Then I had to send for all my medical records, lots more time. In addition to our personal distress, our Executive Administrator's sister and her father died during this time too. Needless to say, that between my illness and recovery, followed by my COO's illnesses, and deaths of so many of our loved ones, many things slipped through the cracks and were missed and for us, it has definitely been unavoidable. How can so much happen in such a small business? So in summary, I was incapacitated in early 2005 through late 2009 and my COO, my back up and right arm had been pulled out of the picture in 2006, never to return at full capacity again, leaving me in most dire circumstances.

I am attaching my medical records, a letter from my doctor and all the death certificates for Ken and my brother, my Mom and my Dad. I also have filed the forms to change the address for these patents to our home address so we receive the notices in the future. Please seriously consider all that has happened to us to cause us to have this unavoidable delay in paying these maintenance fees and to help me to resolve this error as I have passionately worked for the last twenty years investing much to make products that would be better for the tiny preemie infants I deeply care about and for whom they were developed. We sincerely thought that we had all our bases covered with regard to our patent fees but with all that plagued us it was unavoidable that we missed these dates. Please help me to redeem my patents that I have worked so hard to achieve. It seems almost unbelievable that, in such a small office, so many trials could occur, but they did.

With highest hopes;



M. Sharon Rogone RNC-E, CEO
Small Beginnings Inc.
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Hesperia, CA 92345
760-949-7707
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Small Beginnings, Inc.
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Response to Petition

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In re Patent No. 6,381,787
Issued: May 7, 2002
Application No.: 09/500,736
Filing Date: February 9, 2000
Attorney Docket No.

This is a request for information in response to the petition under 37 CFR 1.378(b), filed July 11, 2011.

The petition is **dismissed**.

A review of the petition document reveals that it is signed only by M. Sharon Rogone who is one of two joint inventors. It is noted that 37 CFR 1.33(b) provides, that:

(b) *Amendments and other papers.* Amendments and other papers, except for written assertions pursuant to § 1.27(c)(2)(ii) of this part, filed in the application must be signed by:

- (1) A registered patent attorney or patent agent of record appointed in compliance with § 1.32(b);
- (2) A registered attorney or agent not of record who acts in a representative capacity under the provisions of § 1.34;
- (3) An assignee as provided for under § 3.71(b) of this chapter; or
- (4) All of the applicants (§ 1.41(b)) for patent, unless there is an assignee of the entire interest and such assignee has taken action in the application in accordance with § 3.71 of this chapter.

The petition must be dismissed, without prejudice, because it is only signed by one of the joint inventors. The renewed petition must be signed by either all of the joint inventors, a registered patent attorney, or an authorized representative of the assignee that is empowered under 37 CFR 3.73(b).

It is noted that petition under 37 CFR 1.378(b) filed in U.S. Patent No. 5,613,502 was accompanied by several supporting documents which were not made a part of this petition, notwithstanding petitioner's request. These documents are material to the instant petition, however. Petitioner is cautioned, however, that each patent matter is exclusive in, and of, itself. Accordingly, petitioner is required to file the supporting documents in the subject application, and, going forward, a separate "Response to Request for Information" and any other filings should be filed in each patent matter.

It is further noted that the address cited on the petition differs from the address of record. Petitioner should file a request to change the correspondence address with the Response to Request for Information.

STATEMENT UNDER 37 CFR 3.73(b)

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Applicant/Patent Owner: M. Sharon Rogone (AKA Mary S. Rogone) / Philip N. Rogone

Application No./Patent No.: 09500736 / 6381787

Filed/Issue Date: 04-01-1998 / 04-03-2001

AUG 26 2011

Titled: **INFANT POSITIONING DEVICE**

OFFICE OF PETITIONS

Small Beginnings Inc. , a Corporation

(Name of Assignee)

(Type of Assignee, e.g., corporation, partnership, university, government agency, etc.)

states that it is:

1. ☒ the assignee of the entire right, title, and interest in;
2. ☐ an assignee of less than the entire right, title, and interest in
(The extent (by percentage) of its ownership interest is _____ %); or
3. ☐ the assignee of an undivided interest in the entirety of (a complete assignment from one of the joint inventors was made)

the patent application/patent identified above, by virtue of either:

A. ☒ An assignment from the inventor(s) of the patent application/patent identified above. The assignment was recorded in the United States Patent and Trademark Office at Reel 010595, Frame 0894, or for which a copy therefore is attached.

OR

B. ☒ A chain of title from the inventor(s), of the patent application/patent identified above, to the current assignee as follows:

1. From: Mary S. Rogone / Philip N. Rogone To: Small Beginnings Inc.

The document was recorded in the United States Patent and Trademark Office at

Reel _____, Frame _____, or for which a copy thereof is attached.

2. From: _____ To: _____

The document was recorded in the United States Patent and Trademark Office at

Reel _____, Frame _____, or for which a copy thereof is attached.

3. From: _____ To: _____

The document was recorded in the United States Patent and Trademark Office at

Reel _____, Frame _____, or for which a copy thereof is attached.

☐ Additional documents in the chain of title are listed on a supplemental sheet(s).

☐ As required by 37 CFR 3.73(b)(1)(i), the documentary evidence of the chain of title from the original owner to the assignee was, or concurrently is being, submitted for recordation pursuant to 37 CFR 3.11.

[NOTE: A separate copy (i.e., a true copy of the original assignment document(s)) must be submitted to Assignment Division in accordance with 37 CFR Part 3, to record the assignment in the records of the USPTO. See MPEP 302.08]

The undersigned (whose title is supplied below) is authorized to act on behalf of the assignee.

M Sharon Rogone
Signature

8/16/11
Date

M Sharon Rogone ETAL

CEO Small Beginnings Inc.

Printed or Typed Name

Title

This collection of information is required by 37 CFR 3.73(b). The information is required to obtain or retain a benefit by the public which is to file (and by the USPTO to process) an application. Confidentiality is governed by 35 U.S.C. 122 and 37 CFR 1.11 and 1.14. This collection is estimated to take 12 minutes to complete, including gathering, preparing, and submitting the completed application form to the USPTO. Time will vary depending upon the individual case. Any comments on the amount of time you require to complete this form and/or suggestions for reducing this burden, should be sent to the Chief Information Officer, U.S. Patent and Trademark Office, U.S. Department of Commerce, P.O. Box 1450, Alexandria, VA 22313-1450. DO NOT SEND FEES OR COMPLETED FORMS TO THIS ADDRESS. SEND TO: Commissioner for Patents, P.O. Box 1450, Alexandria, VA 22313-1450.

If you need assistance in completing the form, call 1-800-PTO-9199 and select option 2.



US006381787B1

(12) **United States Patent**
Rogone et al.

(10) **Patent No.:** **US 6,381,787 B1**
(45) **Date of Patent:** **May 7, 2002**

(54) **INFANT POSITIONING DEVICE**

(75) **Inventors:** **Mary S. Rogone; Philip N. Rogone,**
both of Victorville, CA (US)

(73) **Assignee:** **Small Beginnings, Inc.,** Victorville, CA
(US)

(*) **Notice:** Subject to any disclaimer, the term of this
patent is extended or adjusted under 35
U.S.C. 154(b) by 0 days.

(21) **Appl. No.:** **09/500,736**

(22) **Filed:** **Feb. 9, 2000**

(51) **Int. Cl.⁷** **A47C 21/08; A61G 9/06**

(52) **U.S. Cl.** **5/655; 5/420; 5/425**

(58) **Field of Search** **5/655; 417; 419;**
5/420; 424; 425; 427; 482; 485

(56) **References Cited**

U.S. PATENT DOCUMENTS

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* cited by examiner

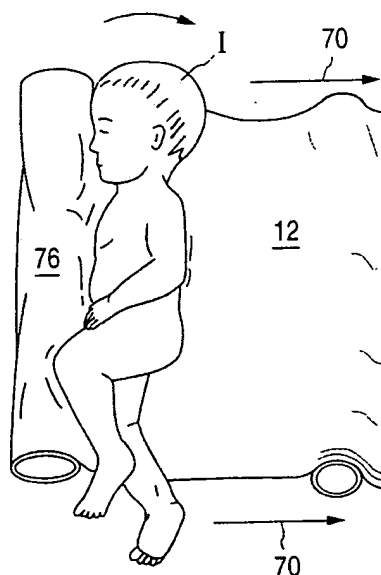
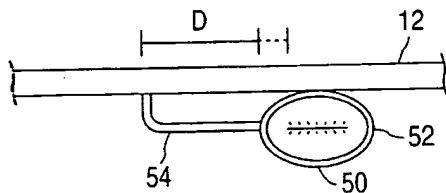
Primary Examiner—Robert G. Santos

(74) *Attorney, Agent, or Firm*—Skjerven Morrill
MacPherson LLP; Theodore P. Lopez

(57) **ABSTRACT**

An infant positioning device which provides the ability to
move an infant, a preterm infant, and/or a newborn between
and including a supine, prone, or side-lying position, with
little or no tactile stimulation of the infant caused by human
touch.

18 Claims, 5 Drawing Sheets



CHANGE OF CORRESPONDENCE ADDRESS Patent

Address to:
Mail Stop Post Issue
Commissioner for Patents
P.O. Box 1450
Alexandria, VA 22313-1450

Patent Number 6381787

Issue Date March 25, 1997

Application Number 09500736

Filing Date Jul. 23, 1992

First Named Inventor Mary S. Rogone ETAL

Attorney Docket
Number

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Please change the Correspondence Address for the above-identified patent to:

☐ The address associated with Customer Number:

OR

☒ **Firm or
Individual Name** MARY SHARON ROGONE

140430 CHOCO RD.

Address

City APPLE VALLEY

State CA.

ZIP 92307

Country USA

Telephone 760-220-2141

Email msharonr@yahoo.com

This form cannot be used to change the data associated with a Customer Number. To change the data associated with an existing Customer Number use "Request for Customer Number Data Change" (PTO/SB/124).

This form will not affect any "fee address" provided for the above-identified patent. To change a "fee address" use the "Fee Address Indication Form" (PTO/SB/47).

I am the:

☒ Patentee.

☐ Assignee of record of the entire interest. See 37 CFR 3.71.
Statement under 37 CFR 3.73(b) is enclosed. (Form PTO/SB/96).

☐ Attorney or agent of record. Registration Number _____

Signature

**Typed or
Printed Name** M SHARON ROGONE

Date 6/3/2011

Telephone 760-949-7707

NOTE: Signatures of all the inventors or assignees of record of the entire interest or their representative(s) are required. Submit multiple forms if more than one signature is required, see below*.

☒ *Total of 3 forms are submitted.

This collection of information is required by 37 CFR 1.33. The information is required to obtain or retain a benefit by the public which is to file (and by the USPTO to process) an application. Confidentiality is governed by 35 U.S.C. 122 and 37 CFR 1.11 and 1.14. This collection is estimated to take 3 minutes to complete, including gathering, preparing, and submitting the completed application form to the USPTO. Time will vary depending upon the individual case. Any comments on the amount of time you require to complete this form and/or suggestions for reducing this burden, should be sent to the Chief Information Officer, U.S. Patent and Trademark Office, U.S. Department of Commerce, P.O. Box 1450, Alexandria, VA 22313-1450. DO NOT SEND FEES OR COMPLETED FORMS TO THIS ADDRESS. **SEND TO: Mail Stop Post Issue, Commissioner for Patents, P.O. Box 1450, Alexandria, VA 22313-1450.**

If you need assistance in completing the form, call 1-800-PTO-9199 and select option 2.

**PETITION TO ACCEPT UNAVOIDABLY DELAYED PAYMENT OF
MAINTENANCE FEE IN AN EXPIRED PATENT (37 CFR 1.378(b))**

Docket Number (Optional)

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Mail to: Mail Stop Petition
Commissioner for Patents
P.O. Box 1450
Alexandria VA 22313-1450
Fax: (571) 273-8300

NOTE: If information or assistance is needed in completing this form, please contact Petitions Information at (571) 272-3282.

Patent Number: 6381787

Application Number: 09500736

Issue Date: MAY 7, 2002

Filing Date: FEB. 9, 2000

CAUTION: Maintenance fee (and surcharge, if any) payment must correctly identify: (1) the patent number (or reissue patent number, if a reissue) and (2) the application number of the actual U.S. application (or reissue application) leading to issuance of that patent to ensure the fee(s) is/are associated with the correct patent. 37 CFR 1.366(c) and (d).

Also complete the following information, if applicable:

The above-identified patent:

☐ is a reissue of original Patent No. _____ original issue date _____;
original application number _____
original filing date _____

☐ resulted from the entry into the U.S. under 35 U.S.C. 371 of international application
_____ filed on _____

CERTIFICATE OF MAILING OR TRANSMISSION (37 CFR 1.8(a))

I hereby certify that this paper (along with any paper referred to as being attached or enclosed) is

(1) being deposited with the United States Postal Service on the date shown below with sufficient postage as first class mail in an envelope addressed to Mail Stop Petition, Commissioner for Patents, P.O. Box 1450, Alexandria, VA 22313-1450 OR

(2) transmitted by facsimile on the date shown below to the United States Patent and Trademark Office at (571) 273-8300.

Date

Signature

Typed or printed name of person signing Certificate

[Page 1 of 4]

This collection of information is required by 37 CFR 1.378(b). The information is required to obtain or retain a benefit by the public which is to file (and by the USPTO to process) an application. Confidentiality is governed by 35 U.S.C. 122 and 37 CFR 1.11 and 1.14. This collection is estimated to take 8 hours to complete, including gathering, preparing, and submitting the completed application form to the USPTO. Time will vary depending upon the individual case. Any comments on the amount of time you require to complete this form and/or suggestions for reducing this burden, should be sent to the Chief Information Officer, U.S. Patent and Trademark Office, U.S. Department of Commerce, P.O. Box 1450, Alexandria, VA 22313-1450. DO NOT SEND FEES OR COMPLETED FORMS TO THIS ADDRESS. SEND TO: Mail Stop Petition, Commissioner for Patents, P.O. Box 1450, Alexandria, VA 22313-1450.

If you need assistance in completing the form, call 1-800-PTO-9199 and select option 2.

Under the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number.

1. SMALL ENTITY

☒ Patentee claims, or has previously claimed, small entity status. See 37 CFR 1.27

2. LOSS OF ENTITLEMENT TO SMALL ENTITY STATUS

☐ Patentee is no longer entitled to small entity status. See 37 CFR 1.27(g)

3. MAINTENANCE FEE (37 CFR 1.20(e)-(g))

The appropriate maintenance fee must be submitted with this petition, unless it was paid earlier.

NOT Small Entity			Small Entity		
Amount	Fee	(Code)	Amount	Fee	(Code)
<input type="checkbox"/> \$ _____	3 ½ yr fee	(1551)	<input type="checkbox"/> \$ <u>490</u>	3 ½ yr fee	(2551)
<input type="checkbox"/> \$ _____	7 ½ yr fee	(1552)	<input type="checkbox"/> \$ <u>1240</u>	7 ½ yr fee	(2552)
<input type="checkbox"/> \$ _____	11 ½ yr fee	(1553)	<input type="checkbox"/> \$ <u>1730.00</u>	11 ½ yr fee	(2553)

MAINTENANCE FEE BEING SUBMITTED \$ 1730.00

4. SURCHARGE

The surcharge required by 37 CFR 1.20(i)(1) of \$ 700.00 (Fee Code 1557) must be paid as a condition of accepting unavoidably delayed payment of the maintenance fee.SURCHARGE FEE BEING SUBMITTED \$ 700.00

5. MANNER OF PAYMENT

- ☒ Enclosed is a check for the sum of \$ 2430.00
- ☐ Please charge Deposit Account No. _____ the sum of \$ _____
- ☐ Payment by credit card. Form PTO-2038 is attached.

6. AUTHORIZATION TO CHARGE ANY FEE DEFICIENCY

☐ The Director is hereby authorized to charge any maintenance fee, surcharge or petition fee deficiency to Deposit Account No. _____

Under the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number.

7. OVERPAYMENT

As to any overpayment made, please

☐ Credit to Deposit Account No. _____

OR

☒ Send refund check**WARNING:**

Petitioner/applicant is cautioned to avoid submitting personal information in documents filed in a patent application that may contribute to identity theft. Personal information such as social security numbers, bank account numbers, or credit card numbers (other than a check or credit card authorization form PTO-2038 submitted for payment purposes) is never required by the USPTO to support a petition or an application. If this type of personal information is included in documents submitted to the USPTO, petitioners/applicants should consider redacting such personal information from the documents before submitting them to the USPTO. Petitioner/applicant is advised that the record of a patent application is available to the public after publication of the application (unless a non-publication request in compliance with 37 CFR 1.213(a) is made in the application) or issuance of a patent. Furthermore, the record from an abandoned application may also be available to the public if the application is referenced in a published application or an issued patent (see 37 CFR 1.14). Checks and credit card authorization forms PTO-2038 submitted for payment purposes are not retained in the application file and therefore are not publicly available.

8. SHOWING

The enclosed statement will show that the delay in timely payment of the maintenance fee was unavoidable since reasonable care was taken to ensure that the maintenance fee would be paid timely and that this petition is being filed promptly after the patentee was notified of, or otherwise became aware of, the expiration of the patent. The statement must enumerate the steps taken to ensure timely payment of the maintenance fee, the date and the manner in which the patentee became aware of the expiration of the patent, and the steps taken to file the petition promptly.

9. PETITIONER(S) REQUESTS THAT THE DELAYED PAYMENT OF THE MAINTENANCE FEE BE ACCEPTED AND THE PATENT REINSTATED._____
Signature(s) of Petitioner(s)_____
Date

M Sharon Rogone(AKAMarySRogone)Philip N. Rogone

Typed or printed name(s)_____
Registration Number, if applicable

14043 CHOCO RD

760-220-2141

Address_____
Telephone Number

APPLE VALLEY, CA 92307 usa

Address**ENCLOSURES:**

Maintenance Fee Payment



Statement why maintenance fee was not paid timely



Surcharge under 37 CFR 1.20(i)(1) (fee for filing the maintenance fee petition)



Other:

MEDICAL RECORDS, DEATH CERTIFICATES, LETTER FROM MD

Under the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number.

37 CFR 1.378(d) states: "Any petition under this section must be signed by an attorney or agent registered to practice before the Patent and Trademark Office, or by the patentee, the assignee, or other party in interest."

Signature

Date

M Sharon Rogone/Philip N. Rogone

Type or printed name

Registration Number, if applicable

STATEMENT

(In the space below, please provide the showing of unavoidable delay recited in paragraph 8 above.)

See attached letters and documents--the same one for all 3 patents



(Please attach additional sheets if additional space is needed)

Statement of Fact

I, Pamela Croteau, have worked since 2003 for Small Beginning as a bookkeeper, and later promoted to Executive Administrator, as misfortune continued to happen to all of us.

I was aware of Mr. Lopez work to help Small Beginnings after the troubles with Skjerven's law firm in 2004. I knew that Sharon, as CEO was the responsible person. She and Ken, her COO had made a master calendar to make sure we had all our bases covered with regard to the Patent filings, and much more. The unforeseen fall and back problems rendered Sharon very incapacitated and unable to fulfill her role in the business. Then Ken's family heartbreak followed and I personally lost my sister in February of 2010 and my father in November of 2010. This compounded all the calamities of this small company. When we hired a new person in late 2010 to take over Ken's role in the business, we found he had buried the master calendar in all of his unfiled paperwork. This is when Sharon began trying to redeem the patents that had expired.


Pamela R. Croteau Exec. Admin.

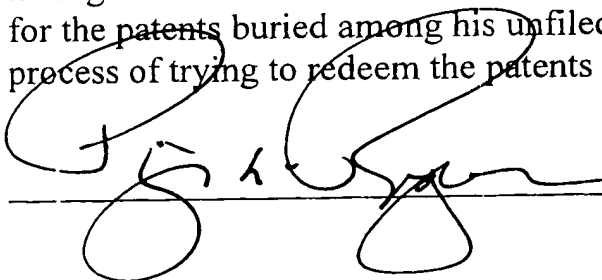
Statement of Fact

I am Philip Rogone husband to Sharon and the current Chief Operating Officer for Small Beginnings Inc. Prior to my recent promotion I was the VP of Sales and Marketing and was promoted after the tragic loss of our friend and business partner Kenneth S. Croteau. Ted Lopez our friend and attorney agreed to help us with our patent work after the firm of Skjerven's law was fired in 2004. Sharon and Ken were responsible with handling the patents, contracts, and GPO negotiations as well as handling all the FDA regulation requirements while I was focusing on Sales and Distributor training.

Sharon's back problems started after the head of neurosurgery performed a bilateral laminectomy which caused her to lose over two inches in height, which created severe nerve damage from the collapsing of her spine. She could barely walk. This was followed a year later with a second surgery which rendered her with a paralyzed left leg which required physical therapy three times a day. Needless to say I was also out of the office to care for her. We barely got back to a normal schedule when Ken's brother-in-law Ricky took very ill with cancer. Ken took complete care of him. Just after Ricky passed away Ken began acting strange. He was forgetting conversations and tasks he had been assigned to in the office. He staggered in one morning at almost 11am and we rushed him to the hospital. It was viral meningitis. What followed was months of one medical nightmare after another until he was diagnosed with cancer and died just ten months later. Sharon was only able to come in on a part time basis during all this and Ken was out for almost two years. During all this Sharon lost her father and mother four days apart a year before Ken passed. Our executive assistant Pam lost her sister and father also during this time.

Since our whole office consisted of the four of us with a girl to answer phones and process orders, we were operating inefficiently to say the least.

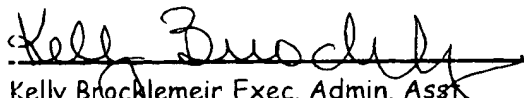
When we hired Kelly to help assume Ken's duties in late 2010, while going through his desk she found the master calendar that Ken and Sharon had made up for the patents buried among his unfiled paperwork. This is when Sharon began the process of trying to redeem the patents that had expired.



Philip N. Rogone PA. RCP. COO.

Statement of Fact

I, Kelly Brocklemeyer, have worked for Small Beginnings since 2009; I began as the part-time receptionist and order processor and later was promoted to the full time position of Executive Administrative Assistant when Ken became too ill to continue working. I knew that Sharon, as CEO was the responsible person and Ken was her COO. I knew of all the unforeseen calamities that had occurred over the last several years and just as I started working here Sharon was returning to work, trying to pick up all the pieces and Ken's health was failing and he was gone most of the time. I was soon assuming more and more responsibility for Ken's role, until Sharon promoted me in mid 2010 and hired another to take my place. Sharon, Pam, Phil, and even Ken (when he was feeling well enough) were all trying to get me up to speed to fulfill Ken's role. We began finding many errors that Ken had been making at work, given all of his family and health issues that he had been dealing with. We also found he had buried the master calendar in a mountain of his unfiled paperwork. This is when Sharon began trying to redeem the patents that had expired.


Kelly Brocklemeyer Exec. Admin. Asst.

STATE OF CALIFORNIA
CERTIFICATION OF VITAL RECORD

COUNTY of SAN BERNARDINO

DEPARTMENT OF PUBLIC HEALTH

351 N. MT. VIEW AVENUE, SAN BERNARDINO, CALIFORNIA 92415-0010

CERTIFICATE OF DEATH

3201036011290

STATE FILE NUMBER		LOCAL REGISTRATION NUMBER	
1. NAME OF DECEDENT - FIRST (Given)		3. LAST (Family)	
KENNETH		CROTEAU	
2. MIDDLE		4. DATE OF BIRTH - month/day/year	
STEEVES		06/16/1953	
5. AGE - Yrs.		6. SEX	
57		M	
7. DATE OF DEATH - month/day/year			
12/06/2010			
8. HOUR (24 hours)			
1014			
9. BIRTH STATE/OTHER COUNTRY			
CT			
10. SOCIAL SECURITY NUMBER			
551-94-3459			
11. EVER IN U.S. ARMED FORCES			
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNK			
12. MARITAL STATUS - at time of death			
MARRIED			
13. EDUCATION - Highest Grade Completed			
BACHELOR			
14. WAS DECEDENT A NATURALIZED CITIZEN? If yes, at what time or place?			
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
15. DECEDENT'S RACE - List 1 to 3 races, may be listed as mixed race (see back)			
WHITE, CANADIAN, FRENCH			
16. USUAL OCCUPATION - Type of work for most of the 12 months prior to death			
CHIEF OPERATIONS OFFICER			
17. KIND OF BUSINESS OR INDUSTRY in which decedent was employed			
MANUFACTURING			
18. YEARS IN OCCUPATION			
15			
19. DECEDENT'S RESIDENCE - street and number, or location			
7245 JENKINS AVE			
20. CITY			
HESPERIA			
21. COUNTY			
SAN BERNARDINO			
22. ZIP CODE			
92345			
23. YEARS IN COUNTY			
29			
24. STATE/FOREIGN COUNTRY			
CA			
25. DECEASED'S NAME, RELATIONSHIP			
W. DEBBRA CROTEAU, WIFE			
26. DECEASED'S ADDRESS - street and number, or care home name, city of birth, state and zip			
7245 JENKINS AVE, HESPERIA, CA 92345			
27. NAME OF SURVIVOR SPOUSE/SURVIVOR			
WINNIFRED			
28. MIDDLE			
DEBBRA			
29. LAST (BIRTH NAME)			
BOHRINGER			
30. NAME OF FATHER/MOTHER - FIRST			
ROBERT			
31. MIDDLE			
LEO			
32. LAST			
CROTEAU			
33. BIRTH STATE			
MA			
34. NAME OF MOTHER/MOTHER - FIRST			
BARBARA			
35. MIDDLE			
HELEN			
36. LAST (BIRTH NAME)			
STEEVES			
37. BIRTH STATE			
NY			
38. DATE OF DEATH - month/day/year			
12/10/2010			
39. PLACE OF DEATH - street and number, or location			
SUNSET HILLS MEMORIAL PARK			
7245 JENKINS AVE, HESPERIA, CA 92345			
40. TYPE OF DISPOSITION			
CR/BU			
41. NAME OF FUNERAL ESTABLISHMENT			
SUNSET HILLS MORTUARY INC.			
42. LICENSE NUMBER			
FD1640			
43. SIGNATURE OF LOCAL REGISTRAR			
MAXWELL OHIKHUARE, MD			
44. DATE - month/day/year			
12/10/2010			
45. PLACE OF DEATH			
RESIDENCE/HOSPICE			
46. COUNTY			
SAN BERNARDINO			
47. FACILITY ADDRESS OR LOCATION WHERE FOUND (street and number, or location)			
7245 JENKINS AVE			
48. CITY			
HESPERIA			
49. CAUSE OF DEATH			
IMMEDIATE CAUSE - NO CARDIOPULMONARY ARREST			
RENAL CELL CARCINOMA			
50. UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST			
NONE			
51. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE (even if not listed)			
NONE			
52. WAS OPERATION PERFORMED? IF ANY CONDITION IN ITEM 51 OR 52? (If yes, list type of operation and date)			
NO			
53. SIGNATURE AND TITLE OF CERTIFIER			
JOHN R. HAWES D.O.			
54. TYPE OF CERTIFYING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE			
HAHN TRINH NGUYEN M.D.			
55. DATE OF CERTIFICATION			
12/03/2010			
56. DATE OF DEATH			
12/05/2010			
57. PLACE OF DEATH			
7245 JENKINS AVE			
58. DESCRIBE HOW INJURY OCCURRED (event which resulted in injury)			
59. LOCATION OF INJURY (street and number, or location, city, and state)			
60. SIGNATURE OF CORNER/DEPUTY CORNER			
61. DATE			
62. TYPE - NAME, TITLE OF CORNER/DEPUTY CORNER			
63. SIGNATURE OF REGISTRAR			
64. DATE			
65. TYPE - NAME, TITLE OF REGISTRAR			
66. SIGNATURE OF REGISTRAR			
67. DATE			
68. TYPE - NAME, TITLE OF REGISTRAR			
69. SIGNATURE OF REGISTRAR			
70. DATE			
71. TYPE - NAME, TITLE OF REGISTRAR			
72. SIGNATURE OF REGISTRAR			
73. DATE			
74. TYPE - NAME, TITLE OF REGISTRAR			
75. SIGNATURE OF REGISTRAR			
76. DATE			
77. TYPE - NAME, TITLE OF REGISTRAR			
78. SIGNATURE OF REGISTRAR			
79. DATE			
80. TYPE - NAME, TITLE OF REGISTRAR			
81. SIGNATURE OF REGISTRAR			
82. DATE			
83. TYPE - NAME, TITLE OF REGISTRAR			
84. SIGNATURE OF REGISTRAR			
85. DATE			
86. TYPE - NAME, TITLE OF REGISTRAR			
87. SIGNATURE OF REGISTRAR			
88. DATE			
89. TYPE - NAME, TITLE OF REGISTRAR			
90. SIGNATURE OF REGISTRAR			
91. DATE			
92. TYPE - NAME, TITLE OF REGISTRAR			
93. SIGNATURE OF REGISTRAR			
94. DATE			
95. TYPE - NAME, TITLE OF REGISTRAR			
96. SIGNATURE OF REGISTRAR			
97. DATE			
98. TYPE - NAME, TITLE OF REGISTRAR			
99. SIGNATURE OF REGISTRAR			
100. DATE			

CERTIFIED COPY OF VITAL RECORDS

STATE OF CALIFORNIA

COUNTY OF SAN BERNARDINO

DATE ISSUED

Dec 13, 2010

This is a true and exact reproduction of the document officially registered and placed on file in the VITAL RECORDS SECTION, SAN BERNARDINO DEPARTMENT OF PUBLIC HEALTH.

Maxwell Ohikhuare
MAXWELL OHIKHUARE, M.D.
COUNTY HEALTH OFFICER
REGISTRAR OF VITAL STATISTICS

002007868

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COO

STATE OF CALIFORNIA

CERTIFICATION OF VITAL RECORD

COUNTY of SAN BERNARDINO

DEPARTMENT OF PUBLIC HEALTH

351 N. MT. VIEW AVENUE, SAN BERNARDINO, CALIFORNIA 92415-0010

CERTIFICATE OF DEATH

3200936011895

STATE FILE NUMBER		LOCAL REGISTRATION NUMBER	
1. NAME OF DECEDENT - FIRST (Given)		3. LAST (Family)	
MARY		SHOFFSTALL	
4. DATE OF BIRTH		5. AGE Yrs.	
03/06/1921		88	
6. SEX		7. DATE OF DEATH	
F		12/26/2009	
8. HOURS (24 Hours)		9. HOURS (24 Hours)	
1330		1330	
10. SOCIAL SECURITY NUMBER		11. EVER IN U.S. ARMED FORCES?	
548-28-3627		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNK	
12. MARITAL STATUS (at Time of Death)		13. DECEASED'S RACE - Up to 3 races may be listed (see worksheet on back)	
DIVORCED		WHITE	
14. EDUCATION - Highest Level Completed (See worksheet on back)		15. WAS DECEDENT BILINGUAL (English/Spanish)? (If yes, see worksheet on back)	
HS GRADUATE		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
16. USUAL OCCUPATION - Type of work for most of life. DO NOT USE RETIRED		17. KIND OF BUSINESS OR INDUSTRY (e.g., grocery store, road construction, employment agency, etc.)	
OWNER OPERATOR		COSMETOLOGY	
18. YEARS IN OCCUPATION		19. YEARS IN INDUSTRY	
20		20	
20. DECEDENT'S RESIDENCE (Street and number or location)		21. CITY	
14043 CHOCO RD		APPLE VALLEY	
22. COUNTY/PROVINCE		23. ZIP CODE	
SAN BERNARDINO		92307	
24. YEARS IN COUNTY		25. STATE/FOREIGN COUNTRY	
1		CA	
26. INFORMANT'S NAME, RELATIONSHIP		27. INFORMANT'S MAILING ADDRESS (Street and number or rural route number, city or town, state, ZIP)	
M SHARON ROGONE, DAUGHTER		14043 CHOCO RD, APPLE VALLEY, CA 92307	
28. NAME OF SURVIVING SPOUSE - FIRST		29. MIDDLE	
30. LAST (Maiden Name)		31. NAME OF FATHER - FIRST	
		MOSES	
32. MIDDLE		33. LAST	
		DESATOFF	
34. BIRTH STATE		35. NAME OF MOTHER - FIRST	
RUSSIA		TANYA	
36. BIRTH STATE		37. LAST (Maiden)	
RUSSIA		SHUBIN	
38. BIRTH STATE		39. PLACE OF FINAL DISPOSITION	
		ROSE HILLS MEMORIAL PARK	
40. DATE OF DISPOSITION		41. TYPE OF DISPOSITION	
01/02/2010		BU	
42. SIGNATURE OF EMBALMER		43. LICENSE NUMBER	
ASHLEY N FINNIE		9146	
44. NAME OF FUNERAL ESTABLISHMENT		45. LICENSE NUMBER	
ROSE HILLS MORTUARY		FD-970	
46. SIGNATURE OF LOCAL REGISTRAR		47. DATE	
MAXWELL OHIKHUARE, MD		12/31/2009	
48. PLACE OF DEATH		49. IF HOSPITAL, SPECIFY ONE	
RESIDENCE - HOSPICE		<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DCA <input type="checkbox"/> Hospice <input checked="" type="checkbox"/> Decedent's Home <input type="checkbox"/> Other	
50. COUNTY		51. CITY	
SAN BERNARDINO		APPLE VALLEY	
52. FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number or location)		53. CITY	
14043 CHOCO RD		APPLE VALLEY	
54. CAUSE OF DEATH		55. DEATH REPORTED TO CORONER?	
END STAGE CORONARY ARTERY DISEASE		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
56. IMMEDIATE CAUSE (Final disease or condition resulting in death)		57. YRS	
58. SECONDARY, list conditions, if any, leading to cause on line A. Enter UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST		59. AUTOPSY PERFORMED?	
		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
60. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 54		61. AUTOPSY PERFORMED?	
NONE		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
62. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 57 OR 61? (If yes, list type of operation and date)		63. USED IN DETERMINING CAUSE?	
NO		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
64. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE AND PLACE STATED FROM THE CAUSES STATED		65. SIGNATURE AND TITLE OF CERTIFIER	
Decedent: Ashish Malhotra M.D.		A91216	
66. TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE		67. DATE	
JOHN R HAWES JR D.O.		12/30/2009	
68. I CERTIFY THAT IN MY OPINION DEATH OCCURRED AT THE HOUR, DATE AND PLACE STATED FROM THE CAUSES STATED		69. INJURED AT WORK?	
04/08/2009 12/16/2009		121. INJURY DATE	
70. MANNER OF DEATH		122. HOUR (24 Hours)	
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		123. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER	
71. PLACE OF INJURY (e.g., home, construction site, wooded area, etc.)			
72. DESCRIBE HOW INJURY OCCURRED (Events which resulted in injury)			
73. LOCATION OF INJURY (Street and number, or location, and city, and ZIP)			
74. SIGNATURE OF CORONER / DEPUTY CORONER		75. DATE	
76. STATE REGISTRAR		77. FAX AUTH. #	
A 215			
78. CENSUS TRACT			
010001001391480			

CERTIFIED COPY OF VITAL RECORDS

STATE OF CALIFORNIA
COUNTY OF SAN BERNARDINO

DATE ISSUED

Jan 5, 2010

This is a true and exact reproduction of the document officially registered and placed on file in the VITAL RECORDS SECTION, SAN BERNARDINO DEPARTMENT OF PUBLIC HEALTH.

*Margaret M Reed mo*MARGARET BEED, M.D.
COUNTY HEALTH OFFICER
REGISTRAR OF VITAL STATISTICS

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001921193

Mother

COUNTY of SAN BERNARDINO

DEPARTMENT OF PUBLIC HEALTH

351 N. MT. VIEW AVENUE, SAN BERNARDINO, CALIFORNIA 92415-0010

CERTIFICATE OF DEATH

3200936011674

STATE FILE NUMBER		LOCAL REGISTRATION NUMBER	
1. NAME OF DECEASED - FIRST (Given)		3. LAST (Family)	
FRANKLIN		SHOFFSTALL	
2. MIDDLE		4. DATE OF BIRTH	
EDWARD		03/19/1920	
5. ALSO KNOWN AS - (List all names of DECEASED)		6. AGE Yrs	
		89	
7. BIRTH STATE/FOREIGN COUNTRY		8. SEX	
ILLINOIS		M	
9. SOCIAL SECURITY NUMBER		10. MARITAL STATUS (At time of death)	
562-05-3631		WIDOWED	
11. EVER IN U.S. ARMED FORCES?		12. DATE OF DEATH	
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK		12/22/2009	
13. EDUCATION - (Highest level attained)		14. DECEASED'S RACE - (Up to 2 races may be listed)	
SOME COLLEGE		WHITE	
15. USUAL OCCUPATION - (Type of work performed or held, DO NOT USE RETIRED)		16. KIND OF BUSINESS OR INDUSTRY - (e.g., grocery store, food commissary, employment agency, etc.)	
OWNER		BARBER SHOP	
17. DECEASED'S RESIDENCE (Street and number or location)		18. YEARS IN OCCUPATION	
16352 WIMBLETON DRIVE		35	
19. CITY		20. YEARS IN COUNTY	
VICTORVILLE		10	
21. COUNTY/PROVINCE		22. STATE/FOREIGN COUNTRY	
SAN BERNARDINO		CALIFORNIA	
23. INFORMANTS NAME, RELATIONSHIP		24. INFORMANTS MAILING ADDRESS (Street and number or rural route number, city or town, state, ZIP)	
M. SHARON ROGONE, DAUGHTER		14043 CHOCO ROAD, APPLE VALLEY, CA 92307	
25. NAME OF SURVIVING SPOUSE - FIRST		26. LAST (Modern Name)	
27. NAME OF FATHER - FIRST		28. LAST	
FRANKLIN		SHOFFSTALL	
29. NAME OF MOTHER - FIRST		30. LAST	
MARY		LINDSEY	
31. DISPOSITION DATE		32. PLACE OF FINAL DISPOSITION	
12/30/2009		RES: M SHARON ROGONE 14043 CHOCO ROAD, APPLE VALLEY, CA 92307	
33. TYPE OF DISPOSITION		34. SIGNATURE OF EMBALMER	
CR/RES		NOT EMBALMED	
35. NAME OF FUNERAL ESTABLISHMENT		36. LICENSE NUMBER	
NEPTUNE SOCIETY RIVERSIDE		FD 1307	
37. SIGNATURE OF LOCAL REGISTRAR		38. DATE	
MAXWELL OHIKHUARE, MD		12/23/2009	
39. PLACE OF DEATH		40. COUNTY	
AT HOME		SAN BERNARDINO	
41. FACILITY ADDRESS & LOCATION WHERE FOUND (Including number or location)		42. CITY	
16352 WIMBLETON DRIVE		VICTORVILLE	
43. CAUSE OF DEATH		44. DEATH REPORTED TO CORONER	
(a) Atherosclerotic with hypertensive cardiovascular disease		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
(b) DISEASE		45. YEARS	
(c) 700908536		46. BIRTH STATE	
(d) 100. BIRTH STATE		47. BIRTH STATE	
(e) 100. BIRTH STATE		48. BIRTH STATE	
(f) 100. BIRTH STATE		49. BIRTH STATE	
(g) 100. BIRTH STATE		50. BIRTH STATE	
(h) 100. BIRTH STATE		51. BIRTH STATE	
(i) 100. BIRTH STATE		52. BIRTH STATE	
(j) 100. BIRTH STATE		53. BIRTH STATE	
(k) 100. BIRTH STATE		54. BIRTH STATE	
(l) 100. BIRTH STATE		55. BIRTH STATE	
(m) 100. BIRTH STATE		56. BIRTH STATE	
(n) 100. BIRTH STATE		57. BIRTH STATE	
(o) 100. BIRTH STATE		58. BIRTH STATE	
(p) 100. BIRTH STATE		59. BIRTH STATE	
(q) 100. BIRTH STATE		60. BIRTH STATE	
(r) 100. BIRTH STATE		61. BIRTH STATE	
(s) 100. BIRTH STATE		62. BIRTH STATE	
(t) 100. BIRTH STATE		63. BIRTH STATE	
(u) 100. BIRTH STATE		64. BIRTH STATE	
(v) 100. BIRTH STATE		65. BIRTH STATE	
(w) 100. BIRTH STATE		66. BIRTH STATE	
(x) 100. BIRTH STATE		67. BIRTH STATE	
(y) 100. BIRTH STATE		68. BIRTH STATE	
(z) 100. BIRTH STATE		69. BIRTH STATE	
(aa) 100. BIRTH STATE		70. BIRTH STATE	
(ab) 100. BIRTH STATE		71. BIRTH STATE	
(ac) 100. BIRTH STATE		72. BIRTH STATE	
(ad) 100. BIRTH STATE		73. BIRTH STATE	
(ae) 100. BIRTH STATE		74. BIRTH STATE	
(af) 100. BIRTH STATE		75. BIRTH STATE	
(ag) 100. BIRTH STATE		76. BIRTH STATE	
(ah) 100. BIRTH STATE		77. BIRTH STATE	
(ai) 100. BIRTH STATE		78. BIRTH STATE	
(aj) 100. BIRTH STATE		79. BIRTH STATE	
(ak) 100. BIRTH STATE		80. BIRTH STATE	
(al) 100. BIRTH STATE		81. BIRTH STATE	
(am) 100. BIRTH STATE		82. BIRTH STATE	
(an) 100. BIRTH STATE		83. BIRTH STATE	
(ao) 100. BIRTH STATE		84. BIRTH STATE	
(ap) 100. BIRTH STATE		85. BIRTH STATE	
(aq) 100. BIRTH STATE		86. BIRTH STATE	
(ar) 100. BIRTH STATE		87. BIRTH STATE	
(as) 100. BIRTH STATE		88. BIRTH STATE	
(at) 100. BIRTH STATE		89. BIRTH STATE	
(au) 100. BIRTH STATE		90. BIRTH STATE	
(av) 100. BIRTH STATE		91. BIRTH STATE	
(aw) 100. BIRTH STATE		92. BIRTH STATE	
(ax) 100. BIRTH STATE		93. BIRTH STATE	
(ay) 100. BIRTH STATE		94. BIRTH STATE	
(az) 100. BIRTH STATE		95. BIRTH STATE	
(ba) 100. BIRTH STATE		96. BIRTH STATE	
(bb) 100. BIRTH STATE		97. BIRTH STATE	
(bc) 100. BIRTH STATE		98. BIRTH STATE	
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CERTIFIED COPY OF VITAL RECORDS

STATE OF CALIFORNIA
COUNTY OF SAN BERNARDINO

DATE ISSUED

Dec 30, 2009

This is a true and exact reproduction of the document officially registered and placed on file in the VITAL RECORDS SECTION, SAN BERNARDINO DEPARTMENT OF PUBLIC HEALTH.

Margaret M. Beed, M.D.

MARGARET BEED, M.D.
COUNTY HEALTH OFFICER
REGISTRAR OF VITAL STATISTICS

This copy not valid unless prepared on engraved border displaying seal and signature of Registrar.



001920415

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

Father

STATE OF CALIFORNIA

CERTIFICATION OF VITAL RECORD

COUNTY of KERN

DEPARTMENT OF PUBLIC HEALTH

1800 MT. VERNON AVE., BAKERSFIELD, CALIFORNIA 93306-3302

CERTIFICATE OF DEATH

3200815003145

STATE FILE NUMBER		LOCAL REGISTRATION NUMBER	
1. NAME OF DECEDENT - FIRST (Given)		3. LAST (Family)	
FRANKLIN		SHOFFSTALL	
2. MIDDLE		4. DATE OF BIRTH mm/dd/yyyy	
MICHAEL		10/01/1945	
5. AGE Yrs.		6. SEX	
62		M	
7. BIRTH STATE/FOREIGN COUNTRY		8. SOCIAL SECURITY NUMBER	
CA		551-64-1559	
9. BIRTH STATE/FOREIGN COUNTRY		10. SOCIAL SECURITY NUMBER	
CA		551-64-1559	
11. EVER IN U.S. ARMED FORCES?		12. MARITAL STATUS (at Time of Death)	
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		DIVORCED	
13. EDUCATION - Highest Level/Degree (See instructions on back)		14. DECEASED'S RACE - Up to 3 races may be listed (see instructions on back)	
HS GRADUATE		CAUCASIAN	
15. USUAL OCCUPATION - Type of work for most of life. DO NOT USE RETIRED		16. KIND OF BUSINESS OR INDUSTRY (e.g., grocery store, road construction, employment agency, etc.)	
HANDYMAN		CONSTRUCTION	
17. DECEASED'S RESIDENCE (Street and number or location)		18. YEARS IN OCCUPATION	
5450 VISTA GRANDE AVE		20	
19. CITY		20. STATE/FOREIGN COUNTRY	
WELDON		CA	
21. COUNTY/PROVINCE		22. ZIP CODE	
KERN		93283	
23. INFORMANT'S NAME, RELATIONSHIP		24. INFORMANT'S MAILING ADDRESS (Street and number or rural route number, city or town, state, ZIP)	
M. SHARON ROGONE, SISTER		14043 CHOCO RD, APPLE VALLEY, CA 92307	
25. NAME OF SURVIVING SPOUSE - FIRST		26. LAST (Decedent Name)	
FRANKLIN		SHOFFSTALL	
27. NAME OF FATHER - FIRST		28. MIDDLE	
FRANKLIN		EDWARD	
29. NAME OF MOTHER - FIRST		30. LAST (Mother)	
MARY		DESATOFF	
31. BIRTH STATE		32. BIRTH STATE	
IL		CA	
33. DISPOSITION DATE mm/dd/yyyy		34. PLACE OF FINAL DISPOSITION	
08/25/2008		M. SHAONE ROGONE, 14043 CHOCO RD, APPLE VALLEY, CA 92307	
35. TYPE OF DISPOSITION(S)		36. SIGNATURE OF EMBALMER	
CR/RES		NOT EMBALMED	
37. NAME OF FUNERAL ESTABLISHMENT		38. SIGNATURE OF LOCAL REGISTRAR	
NEPTUNE SOCIETY		CLAUDIA JONAH, MD	
39. LICENSE NUMBER		40. DATE mm/dd/yyyy	
FD1406		08/18/2008	
41. PLACE OF DEATH		42. IF HOSPITAL, SPECIFY ONE	
RESIDENCE		<input type="checkbox"/> Hospital <input checked="" type="checkbox"/> Home <input type="checkbox"/> Other	
43. COUNTY		44. CITY	
KERN		WELDON	
45. NO. FACILITY ADDRESS (The location where the death occurred)		46. DEATH REPORTED TO CORONER?	
5450 VISTA GRANDE AVE		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
47. CAUSE OF DEATH		48. DEATH REPORTED TO CORONER?	
IMMEDIATE CAUSE (First disease or condition resulting in death)		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
(a) DIABETES MELLITUS		C-1790-08	
49. UNDERLYING CAUSE (Disease or injury that initiated the events resulting in death) LAST		50. INQUIRY PERFORMED?	
ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE, YEARS		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
51. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107		52. AUTOPTV PERFORMED?	
117. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 107 OR 112? (If yes, list type of operation and date)		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
NO		53. USED IN DETERMINING CAUSE?	
118. CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED.		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
119. SIGNATURE AND TITLE OF CERTIFIER		120. LICENSE NUMBER	
A DAWN RATLIFF		121. DATE mm/dd/yyyy	
122. TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE		123. INJURED AT WORK?	
124. CERTIFY THAT IN MY OPINION DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED.		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
125. MANNER OF DEATH		126. INJURY DATE mm/dd/yyyy	
Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined <input type="checkbox"/>		127. HOUR (24 Hours)	
128. PLACE OF INJURY (e.g., home, construction site, wooded area, etc.)		129. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER	
129. DESCRIBE HOW INJURY OCCURRED (Events which resulted in injury)		A DAWN RATLIFF	
130. LOCATION OF INJURY (Street and number, or location, and city, and ZIP)		131. SIGNATURE OF CORONER / DEPUTY CORONER	
132. SIGNATURE OF CORONER / DEPUTY CORONER		133. DATE mm/dd/yyyy	
A DAWN RATLIFF		08/14/2008	
134. STATE REGISTRAR		135. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER	
A		A DAWN RATLIFF, DEPUTY CORONER	

CERTIFIED COPY OF VITAL RECORDS

CLAUDIA JONAH, M.D.
INTERIM HEALTH OFFICER AND LOCAL REGISTRAR
OF BIRTH AND DEATHSSTATE OF CALIFORNIA
COUNTY OF KERN

DATE ISSUED

AUG 18 2008

This is a true and exact reproduction of the document officially registered and placed on file in the office of the VITAL RECORDS SECTION OF THE DEPARTMENT OF PUBLIC HEALTH SERVICES.

B.A. JINADU, MD, MPH
HEALTH OFFICER AND LOCAL REGISTRAR
OF BIRTHS AND DEATHS

* 000267690 *

This copy is not valid unless prepared on engraved border displaying seal and signature of registrar.

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

Brother



CEDARS-SINAI MEDICAL CENTER.

**Spine Center
Orthopaedic Center**

Leonel A. Hunt, MD
Director, Spine Trauma

June 10, 2011

US Patents and Trademarks Office Commissioner

*Re: M. Sharon Rogone
Unavoidable Petitions for Delay of Payment*

To Whom It May Concern:

This letter is to inform you that Ms. Rogone has been my patient 2006. She came to see me after a personal injury and a failed surgery in 2005 which left her with severe pain that was controlled by pain medication and in need of further surgical intervention. In December 2007 we decided to go forward with surgery and performed an L2-5 Extreme Lateral Interbody Fusion. We discovered that due to her previous trauma and surgery she was suffering from left leg paralysis and severe nerve pain to the leg. To help control the pain Ms. Rogone was given a regimen of pain medication and was given an order for rehabilitation and Physical Therapy. Upon examination in October 2009 Ms. Rogone was diagnosed with L1-2 Adjacent Segment Degeneration and I recommended a Lumbar Fusion and proceeded to do the surgery on November 2009. To date Ms. Rogone continues to experience nerve damage with mild paralysis, spasms and pain to the leg; she continues to be on a regimen of nerve medication and muscle relaxants to help control her symptoms.

Should you have any questions or concerns or need further information, please feel free to contact my office at 310-423-9834.

Leonel A. Hunt, M.D.

444 S. San Vicente Blvd. ■ Suite 800 ■ Los Angeles, CA 90048
Office (310) 423-9834 ■ Fax (310) 423-8928
www.cedars-sinai.edu
www.huntspine.com

Patent Maintenance Fees				
1551/2551	1.20(e)	Due at 3.5 years	980.00	490.00
1552/2552	1.20(f)	Due at 7.5 years	2,480.00	1,240.00
1553/2553	1.20(g)	Due at 11.5 years	4,110.00	2,055.00
1554/2554	1.20(h)	Surcharge - 3.5 year - Late payment within 6 months	130.00	65.00
1555/2555	1.20(h)	Surcharge - 7.5 year - Late payment within 6 months	130.00	65.00
1556/2556	1.20(h)	Surcharge - 11.5 year - Late payment within 6 months	130.00	65.00
1557	1.20(i)(1)	Surcharge after expiration - Late payment is unavoidable	700.00	
1558	1.20(i)(2)	Surcharge after expiration - Late payment is unintentional	1,640.00	



CEDARS-SINAI MEDICAL CENTER.

**8700 Beverly Boulevard, Suite 2901
Health Information Department
Los Angeles, CA 90048**

Attn:
ROGONE, MARY SHARON
14043 CHOCO RD
APPLE VALLEY, CALIFORNIA 92307

6/21/11
TEL: 760-946-3151

RE: Records of Ms. Mary Sharon Rogone
MRN#: 100129644

Subject: Records Attached

To Whom it May Concern:

Enclosed are copies of medical records, pursuant to your request.

If you have any questions regarding the above, please contact Release of Information at (310) 423-2259, and one of the Release of Information Specialists will be able to assist you.

Sincerely,

Release of Information Specialist
Health Information Department, Suite 2901
Direct Line: (310) 423-2259

Enclosure: Medical Record Copies

PATIENT: ROGONE, M SHARON

MED REC: 100129644

CEDARS-SINAI MEDICAL CENTER

DICTATOR: MARSHALL GRODE, M.D.

CONSULTATION - NEUROSURGERY

CONSULTANT: MARSHALL GRODE, M.D.

REFERRING PHYSICIAN:

CHIEF COMPLAINT: Pain in the lumbar area and the right leg.

HISTORY OF PRESENT ILLNESS: This is a right-handed 5 ft 4 145-lb female who for a number of years following a twisting accident while getting out of a mobile home developed back pain and pain radiating to the right leg, predominantly in the anterior thigh, of a cramping nature. The pain in the lumbar area is about 4/10. The patient does take Aleve, Tylenol, and Soma for this. The pain in her right leg begins in the right buttock area and transfers over to the anterior thigh and then goes down the anterolateral shin area. This was cramping, burning, and quite severe in nature. This is on the right side only. She feels that the pain is worse with standing and walking. It has been progressively worsening over a two-year period.

She did have a three-level laminectomy in August 2005 at Loma Linda by Dr. Colohan. Postoperatively, however, the patient did not improve. She has continued with similar episodes and symptoms and feels that there is some numbness in the anterior calf on the right and some loss of strength in the right leg as well. She feels that the bladder impairment which she had preoperatively has improved, however.

The patient denies any other focal neurological symptomatology or illnesses.

REVIEW OF SYSTEMS:

She does have some high blood pressure and bradycardia. She does have cramping in her legs, for which she takes potassium, calcium, magnesium occasionally, and occasionally quinine. Occasional PVCs.

ALLERGIES: No known allergies. She is sensitive to codeine and MS because of stomach irritation.

OPERATIONS: Vaginal hysterectomy, anterior repair, and lumbar surgeries.

PHYSICAL EXAMINATION:

HEENT: Head is normocephalic.

NECK: Good range of motion.

BACK: Somewhat straightened, with a loss of lordotic curvature and pain on anterior flexion and some pain on extension. Straight-leg raising, however, was not limited, but she did show some cramping in her right leg.

NEUROLOGIC: Mentation is intact. Gait and station are intact. Cranial nerves reveal normal extraocular movements and visual fields; V-XII intact. Motor exam in the extremities proximal and distal motor groups are 5/5 in the lower extremities. Iliopsoas, quadriceps, hamstrings, anterior tibialis, extensor hallucis longus, and gastrosoleus were 5/5. However, she could not get up from a squat position, but she could stand on her heels and toes. Deep tendon reflexes were symmetrically reduced to 0 to 1+ with no Babinski. Sensory examination to position, deep pain, and touch was intact.

CEREBELLAR: Finger-to-nose was intact.

LABORATORY DATA: MRI scan, with the most recent one from 2005, reveals posterior laminectomies of 3, 4, 5 with degenerative changes at those

levels, including a 2-3 degenerative change and possibly some spinal arachnoiditis.

IMPRESSION: Lumbar pain and sciatic syndrome.

It was recommended that the patient have electrical studies of the lower extremities and paraspinals. In addition, I would recommend flexion and extension of the lumbar spine. In addition, I would get a myelogram followed by detailed CT to see the relationship of the bone to the spinal sac as well as to try and further determine any intradural arachnoiditis. She will be seen after those studies.

XRay of the spine reveals laminectomies of L234, scoliosis and degm disc disease with possible arachnoitis.

MARSHALL GRODE, M.D.

MG/MEDQ/226593356 D: 06/12/2006 T: 06/12/2006 JOB#: 684301

cc: Austin Colohan, M.D.
25455 Barton Rd., Ste. A108
Loma Linda CA 92354

Zaed Elhajani, M.D.
12550 Main St.
Hesperana, CA 92345

Change History and Electronic Signatures:

Edited and signed by GRODE, MARSHALL (518) at 6/13/2006 00:04



CEDARS-SINAI MEDICAL CENTER.

**8700 Beverly Boulevard, Suite 2901
Health Information Department
Los Angeles, CA 90048**

Attn:
ROGONE, MARY SHARON
14043 CHOCO RD
APPLE VALLEY, CALIFORNIA 92307

6/21/11
TEL: 760-946-3151

RE: Records of Ms. Mary Sharon Rogone
MRN#: 100129644

Subject: Records Attached

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Sincerely,

Release of Information Specialist
Health Information Department, Suite 2901
Direct Line: (310) 423-2259

Enclosure: Medical Record Copies

CEDARS-SINAI MEDICAL CENTER
Maxine Dunitz Neurosurgical Institute

PATIENT: ROGONE, M SHARON
MED REC: 100129644
DICTATOR: MARSHALL GRODE, M.D.

NEUROSURGICAL INSTITUTE PROGRESS NOTE
11/13/2006

HISTORY OF PRESENT ILLNESS: The patient has continued with low back pain and leg pain. The leg pain is 80% on the right, and low back pain is 20%. The pain is in the anterior thigh, aching and burning, 8/10 on occasion, especially when walking and standing, and 4/10 at rest. Pain radiates to the anterior shin. She needs to lie down in somewhat recumbent with the leg elevated to relieve the pain. She has no bladder or bowel symptoms. She feels that her legs are weakening because of inactivity.

She has had chiropractic, but no injections. She has difficulty with coital procedure. She has had Soma and Vicodin and Darvocet without relief. She does take Aleve and Tylenol. She also gets some electric-like pain in the left buttock area.

PHYSICAL EXAMINATION:

Strength is 5/5 in the iliopsoas, quadriceps, hamstrings, anterior tibialis, extensor hallucis longus and gastroc soleus. Touch sensation is somewhat diminished in the anterior-lateral shin bilaterally. Reflexes are 2+ at the right knee, absent at the left knee, absent at the ankles. No Babinski. Back has well healed scar. There is flat back. She has some scoliotic changes. She has some discomfort on extension.

REVIEW OF IMAGING: A CT myelogram was reviewed and this shows at the 2-3 level severe disc disease with retrolisthesis and erosion, some flattening of the sac by posterior disc. At L3-4 there is severe narrowing of the disc, possible auto fusion, end plate hypertrophy. Surgical laminectomy is noted. At L4-5 narrowed disc, disc bulge, flattening of the sac, facet hypertrophy, stenosis, and lateral recess changes are noted. At L5-S1 some mild degenerative changes are noted.

IMPRESSION: Lumbar degenerative disease with lateral recess stenosis and radiculopathy.

DISCUSSION: We will have her seen by orthopedic spine for the possibility of extensive decompression and fusion.

MARSHALL GRODE, M.D.

MG/MEDQ/263087760 D: 11/13/2006 T: 11/13/2006 JOB#: 105739

Change History and Electronic Signatures:

Signed by GRODE, MARSHALL (518) at 11/19/2006 10:16

ORTHOPAEDIC CENTER

November 26, 2006

Marshall Grode, M.D.

RE: ROGONE, M SHARON
MR#: 100129644

DR REFERRED HISTORY AND PHYSICAL / NEW PATIENT EVALUATION

DATE OF VISIT: 11/21/2006

Dear Dr. Grode:

I had the pleasure seeing your patient Sharon Rogone today in consultation. She is a 64-year-old female who comes in today with complaints of severe low back pain with right lower extremity pain. She states that her back feels very unstable, and she feels that she has lost tone. She states that at times she feels like her ribs are touching her pelvis and she is unable to walk for more than 10 minutes without significant difficulty. She states that she in August 2005 had multi-level laminectomies which she feels were unsuccessful. She states that at this point in time she wants to know what else can be done. She describes her pain as mostly in the low back region with radiation down the right anterolateral thigh and into the right leg. She states the right leg is positional, but the back pain is continuous. She said she has difficulty standing completely erect. She states that she also feels that it is worsening. She states that reclining or lying down helps relieve her pain, but any walking for a prolonged period of time increases her symptoms significantly. She has had multiple studies, EMGs, nerve conduction studies, stretching, heat and muscle relaxants, which she states has given her some relief, but states that most of her symptoms are continuing to worsen. She denies any bowel or bladder dysfunction or any other complaints.

PAST MEDICAL AND SURGICAL HISTORY: Significant for lumbar laminectomy, as well as hypertension and an irregular heart rate.

CURRENT MEDICATIONS: Lotensin, potassium, Estrace, calcium, magnesium, multivitamin, glucosamine, MSM and Aleve. She also states quinine sulfate as needed.

ALLERGIES TO MEDICATIONS: Morphine and codeine.

SOCIAL HISTORY: The patient works self employed as a nurse. She does not use tobacco products and drinks 1-2 glasses of alcohol per month.

REVIEW OF SYSTEMS:
Significant for some numbness and tingling.

PHYSICAL EXAMINATION:
She is a well-developed, well-nourished female in a moderate amount of discomfort. She has decreased range of motion in the lumbar spine secondary to pain. When asked to stand erect, she is unable to stand completely erect. She has some significant amount of sagittal imbalance of head being in front of her pelvis slightly. She has tenderness to palpation in the midline with a well-healed scar. On neurologic examination she has no motor deficits, however, she has decreased sensation in the L5 distribution on the right -side when compared to the left. She has 2+ deep tendon reflexes at the patella on the right, 1+ at the Achilles on the right, 1+ patellar on the left and 2+ Achilles on

the left.

X-ray evaluation of the lumbar spine shows a degenerative scoliosis, L2-L5, with significant disk space collapse.

ASSESSMENT: At this point time I discussed with Ms. Rogone all the surgical options. I explained to her that she at this point in time has reached the point where she will need to undergo an L2-L5, and possibly S1, fusion. I told her I would more than likely do an XLIF approach for the L2-L5 region with posterior instrumentation and decompression at the L5-S1 region. I explained to her that prior to this I would like to get an MRI of the lumbar spine to look at the status of the L5-S1 disk. I told her if the L5-S1 disk was in fairly decent shape then we will stop her fusion at L5. I told her if there is collapse at that region or if I thought that there is any significant types of instability then I would go down to the sacrum. She is in agreement with this plan of treatment and she will be scheduled for surgery to be dated December 27, 2006.

Thank you for allowing me to participate in the care of this patient.

Leonel A. Hunt, M.D.

LAH/MEDQ/264399050 D: 11/26/2006 T: 11/26/2006 JOB#: 158478

Change History and Electronic Signatures:

Signed by HUNT, LEONEL (8807) at 12/18/2006 11:42

ORTHOPAEDIC CENTER

December 21, 2006

RE: ROGONE, M SHARON
MR#: 100129644

DR REFERRED FOLLOW-UP VISIT

DATE OF VISIT: 12/21/2006

HISTORY: Ms. Rogone comes in today for her preoperative evaluation. She is scheduled to undergo an L2 to L5 XLIF procedure with posterior instrumentation on 12/27/2006. She comes in today stating that her symptoms have not changed and comes in to discuss surgery.

PHYSICAL EXAM: Her neurological exam remains unchanged. She continues to stand with somewhat of a stooped forward posture. No other significant changes.

ASSESSMENT: Lumbar degenerative scoliosis with stenosis, status post laminectomy.

DISCUSSION: At this point in time I discussed with Ms. Rogone all risks, benefits and alternatives of the surgical procedure. I explained to her we would be doing a lateral approach for the interbody grafts with posterior instrumentation. She is well aware of all the risks and wished to proceed with surgery as planned.

Leonel A. Hunt, M.D.

LAH/MEDQ/267330764 D: 12/21/2006 T: 12/22/2006 JOB#: 274194

Change History and Electronic Signatures:
Signed by HUNT, LEONEL (8807) at 1/29/2007 19:58

PATIENT: ROGONE, M SHARON

MED REC: 100129644

CEDARS-SINAI MEDICAL CENTER

DICTATOR: ARTHUR I. WALTUCH, M.D.

PREOPERATIVE HISTORY AND PHYSICAL EXAMINATION

DATE OF ADMISSION: 12/27/2006

HISTORY OF PRESENT ILLNESS: The patient is a 64-year-old Caucasian, married, female nurse, who has been living in High Desert until relatively recently, has had progressive pain and disability in the lumbosacral region with radiation down into her right leg for approximately the last three years. She has had numerous neurological and orthopedic evaluations and had a three-level laminectomy as of August 2005. She was told that she had severe spinal stenosis. She says that in June she had a CT myelogram, EMG and CT scan, and she also had an MRI with contrast in March of this year. The patient was seen by Marshall Grode, M.D., earlier this year in a second neurosurgical opinion, and she presents now because of the intractability of the pain without any significant resolution. As of this date, December 22, she has already been evaluated once again not only by Dr. Marshall Grode, but also by Leonel Hunt, M.D., within the Orthopedic Spine Institute. The options were discussed, and recommendations were made which were accepted by the patient. He apparently has had several conversations with Dr. Hunt and feels that the risks and benefits of the procedure have been carefully described to her, and she wishes to proceed with a very extensive lumbar laminectomy and fusion surgical procedure.

The patient says that until her back got to be quite severe she had a very active lifestyle, riding horseback, but that she had to stop within the last year or so.

ALLERGIES: The patient has no known medication allergies, but she is intolerant to morphine secondary to nausea and vomiting. She says that she had similar reactions to plain codeine.

PERSONAL AND SOCIAL HISTORY: The patient is a nonsmoker, and she only very rarely drinks wine. She is married and as noted above and had three uncomplicated labors and deliveries. She had a vaginal hysterectomy in 1980.

PAST MEDICAL HISTORY: The patient has what she describes as chronic sinus bradycardia, although she does in addition have hypertension.

CURRENT MEDICATIONS: Include Soma one-half tablet b.i.d., Darvocet one-half tablet b.i.d., Vicodin 1 tablet every 4 hours as needed for pain, Lotensin 20 mg b.i.d.. The patient is also on Estrace calcium, magnesium, and Kay-Ciel 8 mEq tablets one daily.

REVIEW OF SYSTEMS:

NEUROLOGICAL: Outside of the issues noted above, she denies any headaches, amaurosis, tinnitus, or vertigo.

CARDIORESPIRATORY: She denies any shortness of breath, dyspnea on exertion, chest pain, palpitations or peripheral edema.

PULMONARY: She denies any wheezing. She does not have chronic cough.

GASTROINTESTINAL: The patient denies any anorexia, nausea, vomiting, diarrhea, constipation, or melena. Her weight has been relatively stable.

FAMILY HISTORY: Her grandfather and father have adult onset diabetes mellitus. I should note that the paternal grandfather is deceased, and his father, who is 86 years old, was just recently diagnosed with adult-onset diabetes mellitus. She has a brother who has pancreatitis and diabetes secondary to multiple drug abuse. Her father also has an irregular heartbeat and has a pacemaker. Her mother is 85 years old and is status post myocardial infarction and has high blood pressure.

PHYSICAL EXAMINATION:

GENERAL: This is a well developed, well nourished, healthy appearing female with scoliosis who does not stand up to her full vertical height but is slightly hunched forward.

VITAL SIGNS: Blood pressure was 164/78, pulse was 70, respirations were 12, temperature was afebrile.

HEENT: The head is normocephalic and atraumatic.

NECK: The neck was relatively supple without mass, thyromegaly or bruit. There was no peripheral lymphadenopathy.

LUNGS: The lungs were clear to auscultation.

HEART: Demonstrated regular rhythm without cardiomegaly and without murmurs, gallops or rubs at this time.

ABDOMEN: The abdomen was free of organomegaly or mass, and the bowel sounds normal. There was no tenderness, guarding, or rebound in the abdomen.

EXTREMITIES: Extremities were free of cyanosis, clubbing or edema.

NEUROLOGIC: Examination was nonfocal.

LABORATORY DATA: An electrocardiogram done the office showed normal sinus rhythm, and although there was minimal technical artifact seen on the tracing, the patient is basically felt to be stable, and the electrocardiogram is essentially normal.

SUMMARY: This pleasant 64-year-old female describes herself as being in the end of her rope with regard to her back pain, and was quite understandable. It has extremely limited her life and her autonomy. She does not appear to have any significant cardiovascular or pulmonary disease that has activity at this time. The patient should be medically cleared for the proposed back surgery on December 27.

ARTHUR I. WALTUCH, M.D.

AIW/MEDQ/267457322 D: 12/22/2006 T: 12/22/2006 JOB#: 279000

Change History and Electronic Signatures:

Signed by WALTUCH, ARTHUR (1930) at 12/28/2006 21:39

PATIENT: ROGONE, M SHARON

MED REC: 100129644

CEDARS-SINAI MEDICAL CENTER

DICTATOR: LEONEL A. HUNT, M.D.

OPERATION REPORT

DATE OF OPERATION: 12/27/2006

PREOPERATIVE DIAGNOSIS: Lumbar degenerative scoliosis.

POSTOPERATIVE DIAGNOSIS: Lumbar degenerative scoliosis.

OPERATION(S) PERFORMED:

1. Anterior interbody fusion through an extreme lateral trans psoas approach L2-3, L3-4 and L4-5.
2. Use of structural peek graft by NuVasive, 10 x 45 at L2-3, 10 x 50 at L3-4 and L4-5.
3. Use of structural peak graft at L2-3, 3-4 and 4-5.
4. Use of morselized allograft with BMP for fusion at L2-3, 3-4 and 4-5.
5. Posterolateral fusion L2-L5.
6. Use of morselized allograft posteriorly for facet fusion, L2-L5.
7. Segmental pedicle screw instrumentation bilaterally L2-L5.
8. Use of intraoperative fluoroscopy.
9. Use of intraoperative neural monitoring anteriorly and posteriorly.
10. Complete discectomies at L2-3, 3-4 and 4-5.

</CO-SURGEONS>

Leonel A. Hunt, M.D. (orthopedic surgery) and Gabriel E. Hunt, M.D.
(neurosurgery)

ASSISTANT:

ANESTHESIOLOGIST:

ANESTHESIA: General endotracheal.

ESTIMATED BLOOD LOSS: 350 cc

BACKGROUND: The patient is a 64-year-old female with progressive pain and disability with pain in the lumbosacral region with radiation down to her right leg for the past two years. She had three-level laminectomy in August 2005 and developed a degenerative scoliosis of her lumbar spine. She had failed all nonoperative treatment via injections as well as physical therapy and continued to have lower extremity symptoms as well as low back pain and progressive disability. X-rays and MRI show significant degenerative scoliosis from L2-L5 with degenerative disk disease and collapse of disk space.

OPERATIVE FINDINGS: The patient was found to have significant disk degeneration at L2-L5 with collapsed disk space height and significant scoliosis.

OPERATIVE PROCEDURE: Once positive identification was made and informed consent was obtained, the patient was brought into the operating room where she was sedated and intubated by anesthesia in the standard fashion. The patient was given 1 gm of Ancef IV, 10 mg of Decadron as well as placing a Foley catheter and placement of arterial line by anesthesia. The patient was then turned to the right side down, left side up lateral decubitus position with axillary pad in place and all bony prominences well padded. The patient was then placed into position for the standard extreme lateral approach for the interbody fusion anteriorly. Positioning was checked on x-ray and skin marks were made. The patient's left flank was then prepped and draped in the normal sterile fashion. Standard two incision approach was made to gain access to the L2-3, 3-4 and 4-5 disk spaces through this approach using the

Maxus retractor and the invasive neural monitoring. L4-5 was approached first with the standard approach passing the dilators carefully, connected to neural monitoring. Each dilator was checked with respect to its position near the nerve stimulating as we were passing through the iliopsoas. Once the last dilator was in place and a retractor was placed, the final retractor blade was assimilated, and it was found to be in good position.

At this point in time, L4-5 disk space was identified and complete L4-5 diskectomy was performed. Once L4-5 diskectomy was complete using trial sizers and a size 10-mm peek lordotic graft would be placed, 10 x 50. All these procedures were performed under x-ray fluoroscopic visualization with constant neural monitoring and running EMGs. Trial sizer was checked in both AP and lateral views and was found to be in good position. BMP with morselized allograft was placed with the peek graft and peek graft was malleted into place. X-rays were taken and it was found to be in good position.

Attention was then carried to the L3-4 disk space. Again, the same procedure passing dilators through the psoas stimulating constantly. As each dilator was passed, it was found to be in good position, checked under x-ray guidance. Fluoroscopy and Maxus retractor was then placed. Maxus retractor blades were tested and were found to be in good position according to neural monitoring as well as on x-ray. Complete 3-4 diskectomy was performed followed by trial sizers of 10 mm x 50 all done under x-ray guidance. Again, the same procedure, a size 10 neutral graft was placed with BMP and morselized allograft. It was press fit into position and x-rays were taken to assess proper placement.

The same procedure was carried out at the L2-3 level again under constant neural monitoring with the dilators being tested with each pass through the psoas. Once L2-3 diskectomy was completed, a size 10 x 45-mm graft was placed after being filled with BMP and morselized allograft. Once all three grafts were in position, running EMGs were performed, and there were no abnormal signals. X-rays were taken in both AP and lateral views and was found to be in good position. The wounds were thoroughly irrigated and closure was begun at this time, deep tissue with #1 Vicryl suture followed by subcutaneous and subcuticular closure with 2-0 Vicryl sutures. Steri-Strips and sterile gauze were placed over the wound, and the patient was then turned to the prone position on the Jackson table for the posterior portion of the case. The patient was then connected for somatosensory as well as EMGs from the neural monitoring department and previous laminectomy incision was marked. The back was then prepped and draped in the normal sterile fashion. Neural monitoring at the end of the case showed signals to be strong at that portion of the case. Once the back was prepped and draped, another gram of Ancef was given and the patient's incision was made. Dissection was carried down to expose the lamina of L2 and the transverse processes of L2 through L5 bilaterally. Once the facet joints and transverse processes were identified, pedicle screws were placed bilaterally at L2, L3, L4 and L5 respectively, all placed under fluoroscopic guidance with constant neural monitoring. The pedicle screws were tested and were found to be in good position under fluoroscopic guidance as well as being tested with neural monitoring.

At this point in time, a high-speed bur was used to arthrodesis facets bilaterally at L2-3, 3-4 and 4-5 and morselized allograft with Grafton putty was placed in the facets as well as laid posterolaterally. Rods were then placed, final tightened into position and AP and lateral plain films were taken to assess position. The wound was thoroughly irrigated and closure was begun at this time. Deep tissue was closed with #1 Vicryl suture followed by subcuticular subcutaneous layer of the skin closed with 2-0 Vicryl suture. The skin edges were approximated with Steri-Strips. Sterile gauze and Tegaderm were placed over the wound. The patient was then turned to the supine position on the hospital bed, extubated and transferred to recovery room in stable condition. There were no complications during this case. The patient

tolerated the procedure well. At the end of the case, all sponge, needle and instrument counts were found to be correct.

During this case, Dr. Gabriel Hunt was the co-surgeon for the majority of the case and was the assistant for the bone grafting and instrumentation portion of the case.

LEONEL A. HUNT, M.D.

LAH/MEDQ/267795111 D: 12/27/2006 T: 12/28/2006 JOB#: 292286

Change History and Electronic Signatures:
Signed by HUNT, LEONEL (8807) at 1/2/2007 12:33

PATIENT: ROGONE, M SHARON

MED REC: 100129644

CEDARS-SINAI MEDICAL CENTER

DICTATOR: JONATHAN M. WEINER, M.D.

CONSULTATION - POSTOPERATIVE
12/28/2006

CONSULTANT: JONATHAN M. WEINER, M.D.

REFERRING PHYSICIAN:

CHIEF COMPLAINT: Postoperative from spine surgery, day #1.

HISTORY OF PRESENT ILLNESS: The patient is a 64-year-old woman with progressive sciatica over the last three years who underwent a three-level laminectomy in 2005. The patient continued having worsening back pain. In March of this year, she went to see Dr. Grode, who began her initial workup which included EMGs, MRIs, and myelogram, and she was then referred to Dr. Gabriel Hunt and Dr. Leonel Hunt. The patient continued to have progressive worsening of leg pain, became more immobilized and incapacity. Dr. Hunt made recommendations for possible surgical intervention which the patient has now agreed to and underwent surgery on the December 27, 2006. The patient is now postoperative day #1, lying comfortably, doing well. I will be following the patient from the ISP Hospital service.

PAST MEDICAL HISTORY: Significant for hypertension, chronic sinus bradycardia, hypokalemia, hysterectomy in 1980 and an episode where the patient had a vasovagal episode causing her to almost pass out which is believed to be secondary to an electrolyte imbalance.

MEDICATIONS: Lotensin 20 mg twice daily; potassium chloride 8 mEq daily; Soma, Darvocet and Vicodin as needed; and Estrace.

ALLERGIES: Morphine sulfate causes nausea and vomiting.

SOCIAL HISTORY: The patient is married and lives in the high desert. Normally is a working nurse. Denies tobacco, alcohol or drug use.

FAMILY HISTORY: Noncontributory.

REVIEW OF SYSTEMS:

The patient has no other systemic complaints with regard to head or neck, cardiac, pulmonary, gastrointestinal, genitourinary, musculoskeletal, neurologic, urologic or immunological systems.

PHYSICAL EXAMINATION:

VITAL SIGNS: Blood pressure 110/52 with a pulse of 64, respiratory rate 20 and temperature of 98 degrees.

HEENT: The patient is normocephalic, atraumatic. The pupils are equal, round and reactive to light and accommodation. Extraocular muscles are intact. Moist mucous membranes. Oropharynx is clear of erythema or exudate.

NECK: No lymphadenopathy, thyromegaly, JVD or carotid bruits.

HEART: Regular rate and rhythm. Normal first and second heart sounds. No third or fourth heart sounds. No murmurs noted.

LUNGS: Clear to auscultation bilaterally. No E to A changes. No dullness to percussion.

ABDOMEN: Soft, nontender and nondistended. No liver or spleen palpable. No other masses noted.

EXTREMITIES: The patient is able to move all four extremities. No clubbing, cyanosis or edema.

NEUROLOGIC: Deferred to the neurosurgical service.

LABORATORY DATA: Of note, the patient has a glucose of 214, a potassium of 3.4.

IMPRESSION: This is a 64-year-old Caucasian woman who will be following postoperatively along with the neurosurgical service.

PLAN:

1. Postoperative day #1. I will continue physical therapy, pain control and IV steroids per the neurosurgical service.
2. The patient has hyperglycemia and is currently on a sliding scale. This is likely due to the steroids that she is on. We will continue sliding scale insulin. As her steroids are tapered, this will likely be unnecessary. If her steroids stay at this dose, she may need to have her sliding scale increased.
3. The patient has some abdominal bloating and discomfort. She has not passed gas yet, and this may be the cause. We will add a proton-pump inhibitor as the patient is on IV steroids and n.p.o.
4. The patient is hypokalemic. This is a chronic problem for her. 20 mEq have been added to the IV fluids. We will add 40 mEq instead.
5. Pain appears to be well controlled currently.
6. Hypertension. The patient has perfect control of her blood pressure at this time. As oral medications, her steroids and lisinopril will be continued.

JONATHAN M. WEINER, M.D.

JMW/MEDQ/267862718 D: 12/28/2006 T: 12/28/2006 JOB#: 553436

Change History and Electronic Signatures:

Signed by WEINER, JONATHAN (3304) at 12/28/2006 13:45

CEDARS-SINAI MEDICAL CENTER

NEUROPHYSIOLOGY DEPARTMENT

4- Northwest

TEL: (310) 423-6841

FAX: (310) 423-0130

INTRAOPERATIVE MONITORING REPORT

PATIENT NAME: ROGONE, M SHARON

MRN: 100129644

SURGEON: Leonel A. Hunt, M.D.

DATE: 12/27/2006

PROCEDURE: Posterior spinal fusion, L2-L5.

NEUROPHYSIOLOGY FELLOW: Mohsin K. Ansari, M.D.

The patient's height 5 feet 3 inches, weight 150 pounds.

INTERPRETATION OF BASELINE RECORDINGS: Bilateral ulnar and posterior tibial SSEPs were borderline delayed for the patient's height. The presence of anesthetics may have partially contributed to the delay in cortical peaks bilaterally at baseline. Right L5, L4 and L3 dermatomal SSEPs were present with reliable wave forms, however, the left L3, L4 and L5 dermatomal SSEPs were not well formed, even at baseline. These baseline findings were informed to the surgeons.

CLINICAL INTERPRETATION OF INTRAOPERATIVE MONITORING: There was a significant change seen in the left posterior tibial SSEPs with a latency shift and more than 50% drop in the amplitude of the wave forms. The surgeons were promptly informed about the findings. This happened towards the end of the case after the pedicle screw testing and rod placement.

There were no other significant changes seen in the other SSEPs that were monitored during the procedure. The left dermatomal SSEPs were not well formed to begin with, hence, hard to interpret whether there was a significant change or not with the dermatomal SSEPs. The bilateral ulnar SSEPs and right posterior tibial SSEPs were essentially stable.

Pedicle screw stimulation was provided during the procedure to ensure proper localization of nerve roots and the details of which can be seen in the actual paper copy of the chart with stimulation at different milliamps.

ABIRAMI MUTHUKUMARAN, M.D.

PHYSICIAN ID: 7870

NEUROPHYSIOLOGY ATTENDING

AM/MEDQ/267890198 D: 12/28/2006 T: 12/29/2006 JOB#: 295801

Change History and Electronic Signatures:

Edited and signed by MUTHUKUMARAN, ABIRAMI (7870) at 12/29/2006 11:36

PATIENT: ROGONE, M SHARON

MED REC: 100129644

CEDARS-SINAI MEDICAL CENTER

DICTATOR: SRIKANTH RAO, M.D.

CONSULTATION - PHYSICAL MEDICINE
01/01/2007

CONSULTANT: SRIKANTH RAO, M.D.

REFERRING PHYSICIAN:

CHIEF COMPLAINT: Decreased activities of daily living.

HISTORY OF PRESENT ILLNESS: This is a 64-year-old female with a history of progressively worsening radicular type of low back pain for the last three years. Also, the patient underwent a three-level lumbar laminectomy back in 2005. She essentially exhausted all conservative management for her chronic radicular pain and, as such, she was referred for surgical intervention. Due to her progressively worsening pain with associated radiating component, the patient was largely immobile, and this affected the quality of her life.

Due to the above, the patient underwent L2 to L5 interbody fusion through a lateral trans psoas approach, lumbar discectomies, fusion on December 27, 2006 under the care of Dr. Hunt. Postoperatively, the patient is recuperating well on the neurosurgical floor.

She has been consulted by Physical Medicine and Rehabilitation in regards to postoperative functional restoration as well as strengthening and ARU candidacy.

Currently, the patient has paresthesias involving the left lower extremity as well as weakness involving the proximal left lower extremity that affect the ability to safely perform activities of daily living and her tasks pertaining to self care, as well as stable ambulation.

ALLERGIES: 1. Codeine.
2. Morphine.

MEDICATIONS:

1. Decadron taper.
2. Colace.
3. Estradiol.
4. Zestril.
5. K-Dur.
6. Zantac.
7. Sliding-scale insulin.
8. Dilaudid p.r.n.
9. Morphine p.r.n.
10. Reglan p.r.n.

PAST MEDICAL HISTORY:

1. Hypertension.
2. Chronic bradycardia.
3. Hypokalemia.
4. History of hysterectomy.
5. History of electrolyte abnormalities.

SOCIAL HISTORY: The patient is married and lives with her husband in the high desert. She lives in a house without stairs. The patient was previously a post-anesthesia care nurse. She is retired from this. She now owns her own business which involves working from home, as well as frequently traveling around the country.

REVIEW OF SYSTEMS:

GENERAL: No fevers or chills.

ENT: No tenderness or vertigo. No sudden visual change.

PULMONARY: No shortness of breath.

CARDIOVASCULAR: No chest pain or shortness of breath.

GASTROINTESTINAL: No nausea or vomiting. Present flatus.

GENITOURINARY: No difficulty urinating.

PSYCHIATRIC: The patient denies history of anxiety. However, there is a remote history of pain/depression for which she is on Zoloft.

HEMATOLOGIC: There is postoperative anemia and leukocytosis.

ENDOCRINE: The patient is on Decadron. She is on sliding-scale insulin for Decadron-mediated hyperglycemia.

PHYSICAL EXAMINATION:

VITAL SIGNS: Stable.

GENERAL: No apparent distress. Alert and oriented.

HEENT: Normocephalic and atraumatic. Pupils are equally round and reactive to light. Extraocular movements are intact.

NECK: Soft, supple; no JVD.

CARDIOVASCULAR: Regular rate and rhythm.

LUNGS: Clear to auscultation.

ABDOMEN: Soft, nontender and nondistended.

EXTREMITIES: No clubbing, cyanosis or edema. No calf tenderness to palpation and no calf swelling; no calf erythema.

NEUROLOGIC: Cranial nerves II-XII are intact. Muscle strength is 5/5 in the upper extremities bilaterally; 5/5 in the right lower extremity bilaterally. Left lower extremity is 2/5 with left hip flexion; 4/5 with left knee extension; 5/5 with left ankle dorsiflexion, extensor hallucis longus and plantar flexion. Sensation to light touch is grossly intact in the upper extremity and the right lower extremity. Left lower extremity sensation is diminished to light touch in the L2 and L3 dermatomes. DTR's are symmetrical in the upper and lower extremities bilaterally. There is no lower extremity clonus noted. Toes are downgoing bilaterally. Gait is not tested.

DATA: CBC: WBC 12.9, hemoglobin 10.7, hematocrit 31.4, platelets 282. BMP: Sodium 139, potassium 4.5, chloride 106, CO2 25, anion gap 8, BUN 11, creatinine 0.7, calcium 8.9. Lumbar spine x-rays pending.

ASSESSMENT: A 64-year-old female with chronic low back pain, progressively worsening lumbar radiculopathy, post-laminectomy syndrome who has essentially failed all conservative management of her chronic radicular back pain, is now status post lumbar decompression and fusion due to chronic degenerative lumbar spondylosis. Currently the patient's neurologic deficits are sensation abnormalities involving the left lower extremity as well as weakness involving the proximal left lower extremity. She has been consulted to Physical Medicine and Rehabilitation in regards to postoperative therapies, functional restoration and ARU candidacy.

PRIMARY REHABILITATION DIAGNOSES:

1. Status post lumbar decompression fusion.
2. Lumbar radiculopathy with associated neurologic deficits, localizing at the level of L2, L3.
3. Paresthesias.
4. Pain in limb.
5. Gait ataxia.
6. Neuropathic pain.

RECOMMENDATIONS:

1. Progressive mobilization with physical therapy.
2. ADL retraining and adaptive equipment with occupational therapy.
3. Maximize time out of bed, up in chair.
4. Continue the use of incentive spirometry.
5. Continue premedicating with p.o. analgesic prior to therapy sessions.

6. DVT prophylaxis.

In regards to ARU candidacy, the patient is an excellent candidate for the acute inpatient rehabilitation ward. Upon medical stabilization pending authorization, clearance and bed availability, suggest transfer to the ARU for comprehensive rehabilitation with emphasis on functional restoration and community reintegration. The above was discussed with the patient and her husband.

Dr. Hunt, thank you for allowing me to participate in the care of this patient. If I can be of any further assistance to you or if any questions arise, please do not hesitate to contact me.

SRIKANTH RAO, M.D.

SR/MEDQ/268149887 D: 01/01/2007 T: 01/01/2007 JOB#: 306395

cc: Jonathan M. Weiner, M.D.

Gabriel E. Hunt, M.D.

Leonel A. Hunt, M.D.

Change History and Electronic Signatures:

Signed by RAO, SRIKANTH (9241) at 1/1/2007 16:10

PATIENT: ROGONE, M SHARON

MED REC: 100129644

CEDARS-SINAI MEDICAL CENTER

DICTATOR: GABRIEL E. HUNT, M.D.

OPERATION REPORT

DATE OF OPERATION: 12/27/2006

PREOPERATIVE DIAGNOSIS: Lumbar degenerative scoliosis.

POSTOPERATIVE DIAGNOSIS: Lumbar degenerative scoliosis.

OPERATION(S) PERFORMED:

1. Anterior interbody fusion through an extreme lateral transthoracic approach at L2-3, L3-4 and L4-5.
2. Use of structural PEEK graft by an invasive 10 x 45 at L2-3, 10 x 50 mm at L3-4 and L4-5.
3. Use of morselized allograft with BMP perfusion at L2-3, 3-4 and 4-5.
4. Posterolateral fusion of L2-L5.
5. Use of morselized allograft posteriorly for facet fusion of L2 through L5.
6. Segmental pedicle screw instrumentation bilaterally at L2 through L5.
7. Use of intraoperative fluoroscopy.
8. Use of intraoperative neural monitoring anteriorly and posteriorly.
9. Complete discectomy at L2-3, L3-4 and L4-5.

SURGEON: Gabriel E. Hunt, Jr., M.D. (Neurosurgery) and Leonel A. Hunt, M.D. (Orthopedic Surgery).

ASSISTANT: None.

ANESTHESIA: General endotracheal.

ESTIMATED BLOOD LOSS: 350 cc.

BACKGROUND: The patient is a 64-year-old woman with progressive pain and instability with pain in the lumbosacral region with radiation down her right leg for the past two years. The patient underwent a laminectomy in August of 2005 and developed degenerative scoliosis of her lumbar spine. She failed all nonoperative treatment as well as physical therapy and continued to have lower extremity symptoms as well as low back pain and progressive disability. X-rays and MRI showed significant degenerative scoliosis from L2 through L5 with degenerative disc disease and collapse of disc space.

OPERATIVE FINDINGS: The patient was found to have significant disc degeneration from L2 through L5 with collapsed discs and disc height and significant scoliosis.

OPERATIVE PROCEDURE: Once positive identification was made and informed consent was obtained the patient was brought to the operating room and intubated by Anesthesia in the customary fashion. The patient was given 1 gram of Ancef and 10 mg of Decadron as well as placement of a Foley catheter and arterial line by Anesthesia. The patient was turned to the right side down, left side up lateral decubitus position with an axillary pad in place and all bony prominences well padded. The patient was then placed in position for a standard extreme lateral approach for the interbody fusion anteriorly. Positioning was checked. The position was verified with fluoroscopy and skin marks were made. The patient's left flank was then prepped and draped in normal sterile fashion.

A standard two-incision approach was made to gain access to L2-3, 3-4 and L4-5 disc spaces through this approach using a MaXcess retractor and then invasive neural monitoring. L4-5 was approached first with the standard approach passing the barriers carefully and carefully

connecting to neural monitoring. Each side was checked with respect to its position near the nerve stimulating as well as passing through the iliopsoas. Once the left dilator was in place, a neural retractor was placed, the final retractor was stimulated and was found to be in good position.

At this point in time the L4-5 disc space was identified and a complete L4-5 discectomy was performed. Once the L4-5 discectomy was complete, using trial sizes and a size 10 PEEK graft will be placed and it was a 10 x 50 mm. All of these procedures were performed under fluoroscopic visualization and constant neural monitoring with running EMGs. Trial fasteners were checked in both AP and lateral views and was found to be in good position. The BMP with morselized allograft was placed within the PEEK graft and the graft was then mounted into place. X-rays were taken and it was found to be in good position.

Attention was then carried to the L3-4 disc space. Again the same procedure using dilators through the psoas stimulating constantly. As each dilator was passed it was found to be in good position and checked under fluoroscopic guidance. The MaxCess retractor was then placed and the retractor beds were tested and found to be in good position. Complete L3-4 discectomy was performed followed by trial sizes of 10 x 50 mm. Everything was done under fluoroscopic guidance. Again, the same procedure with a size 10 graft was placed with BMP and morselized allograft. It was pressed into position and x-rays were taken to assess proper placement.

The same procedure was carried out at L2-3 level again under the constant neural monitoring with the dilators being tested with each pass through the psoas. Once L2-3 discectomy was completed a size 10 x 45 mm graft was placed after being filled with BMP and morselized allograft. Once all three grafts were in position EMGs were performed and there were no abnormal signals. X-rays were taken both AP and lateral views and found to be in good position.

The wounds were sterilely irrigated and closure was begun at this time. Deep tissue with #1 Vicryl suture followed by subcutaneous and subcuticular closure with 2-0 Vicryl sutures. Steri-Strips and a sterile gauze were placed over the wound and the patient was then turned to the prone position on a Jackson table for the posterior part of the case.

The patient was then connected for somatosensory as well as EMG from the neuro monitoring department and previous laminectomy incisions were marked. The back was then prepped and draped in sterile normal fashion. Neural monitoring at the end of the case showed signals to be strong at that portion of the case.

Once the back was scrubbed and draped another gram of Ancef was given to the patient's and the incision was made. Dissection was carried down to expose the lamina at L2 and transverse processes of L2-3 and L5 bilaterally. Once the facet joints and transverse processes were identified, pedicle screws were placed bilaterally at L2, L3, L4 and L5 respectively. All placed under fluoroscopic guidance with constant neural monitoring. The pedicle screws were attached and found to be in good position under fluoroscopic guidance as well as being tested with neural monitoring.

At this point in time a high speed burr was used to arthrodesis the facets bilaterally at L2-3, 3-4 and 4-5 and morselized allograft was placed in the facet joints as well as the posterolateral recess. Rods were then placed, final tightening and positioning and AP and lateral plain films were taken to assess position. The wound was thoroughly irrigated and closure was begun at that time.

Deep tissue was closed with #1 Vicryl suture followed by subcuticular subcutaneous layer of the skin closed with 2-0 Vicryl suture. The skin

edges were approximated with Steri-Strips. Sterile gauze and Tegaderm were placed over the wound. The patient was then turned to the supine position on the hospital bed, extubated and taken to the recovery room without complication.

The patient tolerated the procedure well and the sponge, needle and instrument counts were correct at the end of the case.

During this case Dr. Gabriel E. Hunt, Jr was the assistant for the bone grafting and instrumentation portion of the case.

GABRIEL E. HUNT, M.D.

GEH/MEDQ/268239131 D: 01/02/2007 T: 01/02/2007 JOB#: 309839

Change History and Electronic Signatures:

Edited and signed by HUNT, GABRIEL (8843) at 1/2/2007 23:56

PATIENT: ROGONE, M SHARON

MED REC: 100129644

CEDARS-SINAI MEDICAL CENTER

DICTATOR: JANA BAUMGARTEN, M.D.

HISTORY AND PHYSICAL EXAMINATION

DATE OF ADMISSION: 01/02/2007

REFERRING PHYSICIAN: Leonel A. Hunt, M.D.

CHIEF COMPLAINT: Impaired mobility and activities of daily living.

HISTORY OF PRESENT ILLNESS: Ms. Rogone is a 64-year-old female with history of scoliosis, seen as an outpatient for low back pain with right lower extremity pain and diagnosed with lumbar stenosis, now status post L2 through 5 interbody fusion on 12/27/2006, currently with impaired mobility and activities of daily living.

History was taken from chart review and patient report. The patient reports a long history of scoliosis with complaints of low back pain with right lower extremity pain. She states that approximately a year to a year and a half ago she had multilevel bilateral lumbar laminectomies without significant improvement in her pain. She states she presented to see Dr. Hunt as an outpatient in regards to primarily right lower extremity pain from the pelvis radiating down to the mid shin with lesser complaints of low back pain. She also described some intermittent numbness in the right anterior shin area. She denied any preadmission complaints of left-sided radicular pain, bilateral lower extremity weakness or incontinence. The patient was seen by Dr. Hunt. Imaging was significant for degenerative scoliosis with lumbar stenosis, and the patient was recommended for surgical intervention.

The patient was admitted on 12/27/2006 and underwent L2 through L5 anterior interbody fusion. The patient reports that in the postoperative period she has noted significant proximal left lower extremity weakness and numbness. She states at this point her right lower extremity symptoms appear to be overall improved. She does complain of some "soreness" at the surgical site. Medically the postoperative course overall has been unremarkable other than a vasovagal episode, as well as a mild postoperative anemia and leukocytosis.

The patient currently reports the left lower extremity weakness as above improving overall. She states her pain is overall well controlled on the current oral medications including Lortab and Soma. The patient has been participating in physical therapy and occupational therapy and is currently cleared for ARU transfer today.

PAST MEDICAL HISTORY: Sinus bradycardia, hypertension, hypokalemia, status post hysterectomy.

ALLERGIES: She is intolerant to morphine and codeine with nausea and vomiting.

CURRENT MEDICATIONS: Decadron taper, Colace, estradiol, Zestril, K-Dur, Zantac, sliding scale insulin.

SOCIAL HISTORY: The patient is married and lives with her husband in High Desert. She lives in a one-story home. She was previously a post-anesthesia care nurse and currently develops products/patents for neonatal.

PAST FUNCTIONAL HISTORY: Prior to this admission the patient was independent to modified independent with mobility and ADLs. She states she was limited to approximately five to ten minutes of ambulation at a time secondary to her right lower extremity pain.

CURRENT FUNCTIONAL LEVEL: The patient is min assist 25 feet with a front-wheeled walker. She is overall min assist with ADLs.

REVIEW OF SYSTEMS:

CONSTITUTIONAL: No fevers or chills.

HEENT: No headaches, visual changes or vertigo.

PULMONARY: No shortness of breath.

CARDIOVASCULAR: History of vasovagal episode earlier. No chest pain currently.

GASTROINTESTINAL: No nausea or vomiting. Positive bowel movement this morning.

GENITOURINARY: No history of incontinence. PVRs on this admission have been within normal limits.

PSYCHIATRIC: History of Zoloft as an outpatient.

HEMATOLOGIC: Mild anemia. History of bruising per her report.

ENDOCRINE: No preadmission history of diabetes or thyroid disease.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature 97.8, blood pressure 126/72, pulse 65, respiratory rate 20, saturating 98% on room air.

GENERAL: The patient is in bed, in no acute distress, pleasant.

HEENT: Normocephalic, atraumatic. Extraocular muscles intact. Nares clear. Oropharynx without lesions.

NECK: No JVD.

CARDIAC: Regular rate and rhythm.

LUNGS: Clear to auscultation.

ABDOMEN: Soft and nontender.

EXTREMITIES: No lower extremity edema noted. No calf tenderness or hamstring tightness.

SKIN: Surgical site with Steri-Strips. Ecchymosis noted at the left hip area.

NEUROLOGIC: The patient is alert and oriented. Comprehension and fluency are intact. No facial asymmetry noted. Upper extremity exam 5/5 bilaterally with sensation intact. Negative Hoffmann's. Right lower extremity 5/5 overall. Left lower extremity 5/5 with plantar flexion, dorsiflexion and EHL, 2-3/5 with hip flexion and knee extension. Sensation is decreased to light touch throughout the entire left lower extremity, medial more than laterally throughout. No clonus.

DATA: H&H 10.7/31.4, potassium 4.5. L-spine postoperative films with decreased degree of scoliosis, degenerative disc disease.

PRIMARY REHABILITATION DIAGNOSIS: History of lumbar scoliosis and stenosis status post lumbar decompression and fusion with left lumbar radiculopathy.

COMORBIDITIES: History, history of bradycardia, anemia, history of electrolyte imbalance, status post hysterectomy.

ASSESSMENT AND RECOMMENDATIONS: Ms. Rogone is a very pleasant, 64-year-old female now status post multilevel lumbar decompression and fusion with new left lower extremity weakness, currently with impaired mobility and activities of daily living. The patient has been participating in physical therapy and occupational therapy and may benefit from ARU level therapies prior to anticipated discharge home with family.

PLAN:

1. Rehabilitation therapies. The patient will follow with physical therapy for progressive mobility to include bed mobility, transfer training, gait with appropriate assistive device and bracing (consider knee extension brace), balance training, fall prevention, fall recovery, lower extremity strengthening and range of motion. The patient will follow with occupational therapy for activities of daily living, equipment evaluation, functional transfers, work specification and energy conservation. There does not appear to be an indication for speech therapy or neuropsychology at this time, will continue to follow. Nursing to follow for bowel and bladder

management, medication management and skin management.

2. Spine. The patient is status post fusion as above. Will continue to monitor neurologic exam. Will continue without monitor her surgical sites which are currently clean and dry. Continue recommendations for up out of bed with Cybertec LS brace. Pain is overall under good control on p.r.n. Lortab and Soma. Will continue this on transfer and consider long-acting medication if needed. Will continue a Decadron taper per current recommendations. Will continue sliding scale and Zantac while the patient is on Decadron.
3. Cardiovascular. The patient does have a history of hypertension and brady. We will continue to monitor her vital signs. We will continue Zestril on transfer.
4. Renal/fluids/electrolytes. According to chart review, the patient does have a history of hypokalemia. She is on K-Dur currently. We will check a BMP in the morning.
5. Hematologic. The patient's current H&H is as above. There are no previous CBCs for review. We will check a CBC in the morning.
6. Infectious disease. The patient did have a mild leukocytosis in the postoperative period. We will check a CBC in the morning. The patient is currently afebrile. We will continue to encourage incentive spirometry.
7. GYN. The patient is on estradiol on her current outpatient dose, continue for now.
8. Prophylaxis. Will check a lower extremity ultrasound prior to transfer. Continue Zantac.
9. Psychiatric. According to chart review, the patient was on Zoloft as an outpatient. Will consider restarting this prior to transfer.
10. Team conference to monitor her progress and tailor her program to individual needs. The patient has strengths such as age, motivation and higher prior level of functioning. Estimated length of stay to reach goals of supervised modified independent is 7 to 9 days.

Thank you very much for this very interesting consultation for admission.

JANA BAUMGARTEN, M.D.

JB/MEDQ/268242495 D: 01/02/2007 T: 01/02/2007 JOB#: 568765

cc: Leonel A. Hunt, M.D.

Richard V. Riggs, M.D.

Change History and Electronic Signatures:

Signed by BAUMGARTEN, JANA (7397) at 1/8/2007 15:30

PATIENT: ROGONE, M SHARON

MED REC: 100129644

CEDARS-SINAI MEDICAL CENTER

DICTATOR: RICHARD V. RIGGS, M.D.

DISCHARGE SUMMARY

DATE OF ADMISSION: 01/02/2007

DATE OF DISCHARGE: 01/04/2007

DISCHARGE DIAGNOSES:

1. Status post L2 to L5 anterior interbody fusion due to degenerative scoliosis with lumbar stenosis.
2. Left hip flexor and quadriceps weakness with dysesthesias of proximal left lower extremity due to left lumbar radiculopathy of L2 to L4.
3. History of multilevel bilateral lumbar laminectomies.
4. Hypertension.
5. Hypokalemia.
6. Sinus bradycardia.
7. Status post hysterectomy.

DISCHARGE MEDICATIONS: Dulcolax 5 mg p.o. at bedtime, Decadron 4 mg p.o. q.6 h. for 6 doses then 2 mg p.o. q.6 h. for 8 doses then discontinue, Colace 100 mg p.o. b.i.d., estradiol 1 mg p.o. at bedtime, lisinopril 20 mg p.o. b.i.d., potassium chloride 10 mEq p.o. daily, Lortab 10/500 one tab p.o. q.4 h. as needed for pain, Traumeel ointment applied topically b.i.d. as needed, Zantac 150 mg p.o. b.i.d. Scripts have been written for Decadron and Lortab. The patient had all other medications or will be able to purchase them over the counter.

DISPOSITION: The patient was discharged to home with weekly PT follow-up at Cedars-Sinai.

ACTIVITY: As tolerated with assistance.

DIET: Regular.

FOLLOWUP: With neurosurgery, Dr. Gabriel Hunt, per his office. With primary physician, Dr. Jonathan Weiner, per his office instructions.

HOSPITAL COURSE: The patient was admitted to the rehabilitation unit on 1/2/07 and initiated a comprehensive rehabilitation program to include PT and OT. Upon admission, the patient was initially min assist to standby/setup for ADLs and standby for 60 feet with front-wheel walker for gait. Her barriers at discharge included decreased lower extremity strength, paresthesias, impulsive nature and decreased safety awareness. Due to the patient's brief stay on the inpatient rehabilitation floor, where she only received 2 days of therapy, her overall level of function was essentially the same upon discharge. The patient did not have any significant medical complications while on the rehabilitation ward. Last hemoglobin and hematocrit from 01/03/2007 were 11.9 and 35.1 with a white blood cell count of 8.9 and platelets of 348. BMP was within normal limits other than a slightly decreased sodium at 134 and slightly increased glucose of 147.

RICHARD V. RIGGS, M.D.

RVR/MEDQ/268553673 D: 01/04/2007 T: 01/05/2007 JOB#: 321881

Change History and Electronic Signatures:

Edited and saved as draft by RIGGS, RICHARD (618) at 1/5/2007 18:30

Signed by RIGGS, RICHARD (618) at 1/17/2007 20:50

CEDARS-SINAI MEDICAL CENTER
Maxine Dunitz Neurosurgical Institute

PATIENT: ROGONE, M SHARON
MED REC: 100129644
DICTATOR: Gabriel E. Hunt, M.D.

NEUROSURGICAL INSTITUTE CONSULTATION
12/21/2006

REASON FOR CONSULTATION: Low back pain and radiculopathy.

REFERRING PHYSICIAN: Leonel A. Hunt, M.D.

Dear Dr. Hunt,

I saw Sharon in neurosurgical consultation at your request. As you know, she is a 64-year-old woman that presents with complaints of low back pain with radiation down her right leg. The patient has undergone surgery in the past and this has not given her any relief. The patient is scheduled for lumbar decompression and fusion for her degenerative disease. I am seeing her for further preoperative evaluation. She states her pain is about a 6-7/10, and she is currently taking Soma and Darvocet for her discomfort. Her surgery date is scheduled for December 27, 2006, and I will be involved in the surgical procedure at that point in time. I told the patient to please call me with any questions or concerns, and I would be glad to address those questions as they arose.

Total amount of face-to-face time spent with the patient was 20 minutes.
Total amount of counseling and coordination time was 15 minutes.

GABRIEL E. HUNT, M.D.
ATTENDING NEUROSURGEON

GEH/MEDQ/268967892 D: 01/09/2007 T: 01/09/2007 JOB#: 597046

Change History and Electronic Signatures:
Reviewed by delegate JOHNSEN, AMANDA at 1/16/2007 11:32

ORTHOPAEDIC CENTER

January 18, 2007

RE: ROGONE, M SHARON
MR#: 100129644

DR REFERRED FOLLOW-UP VISIT

DATE OF VISIT: 01/18/2007

HISTORY: Ms. Rogone comes in today for a follow-up visit. She is now 3 weeks status post L2-L5 XLIF procedure with posterior spinal fusion with L4 palsy. She comes in today stating that her right lower extremity and her back feel great. However, she still has significant weakness in the left leg. She has been on physical therapy and rehab for the left lower extremity issues.

PHYSICAL EXAMINATION:

SPINE: Her wounds are well healed. There are no signs or symptoms of infection.

NEUROLOGIC: She has 2/5 left quadriceps. She has 3/5 abductors of the hip on the left-hand side. Sensation is intact. She has 5/5 in all other muscle groups.

ASSESSMENT: Lumbar degenerative scoliosis, status post L2-L5 fusion with an L4 palsy.

DISCUSSION: At this point in time I discussed with Ms. Rogone that I would like for her to continue with her physical therapy. I told her that she is making progress and I explained to her that it would be a slow progression with return of function over time. She states that it is getting somewhat depressing because she is getting anxious for the return of function of her left leg. I explained her that it will take some time but chances are that it will resolve. She will follow up with me again in four weeks' time.

Leonel A. Hunt, M.D.

LAH/MEDQ/270109723 D: 01/18/2007 T: 01/18/2007 JOB#: 381482

Change History and Electronic Signatures:Signed by HUNT, LEONEL (8807) at 1/29/2007 19:39

PATIENT: ROGONE, M SHARON

MED REC: 100129644

CEDARS-SINAI MEDICAL CENTER

DICTATOR: LEONEL A. HUNT, M.D.

DISCHARGE SUMMARY

DATE OF ADMISSION: 12/27/2006

DATE OF DISCHARGE: 01/02/2007

ADMITTING DIAGNOSIS: Degenerative scoliosis.

DISCHARGE DIAGNOSIS: Degenerative scoliosis.

DISCHARGING SERVICES: Leonel A. Hunt, M.D., Orthopedics.

DISPOSITION: To acute rehab.

HISTORY: Ms. Rogone is a 64-year-old female who has had progressive pain and discomfort and disability in the low back region with radiation to her right lower extremity over the last three years. She had multilevel laminectomy in August 2005 and has severe spinal stenosis with degenerative scoliosis on exam. She had difficulty standing in the upright position. Neurologically she had some decrease in sensation in the L5 distribution on the right when compared to the left and diminished Achilles' tendon reflexes as well bilateral on the right and diminished patellar reflexes on the left.

X-ray evaluation and MRI evaluation showed significant degenerative scoliosis of L2 to L5 with significant disk space collapse.

HOSPITAL COURSE: The patient was taken to the operating room on 12/27/2006 where she underwent an L2 to L5 extreme lateral interbody fusion with posterior spinal fusion from L2 to L5. The patient tolerated the procedure well and was transferred to the recovery room in stable condition. On the first evening postop the patient was found to have what appeared to be an L4 palsy or paresis. She had no active motor function in her left quadriceps with weakness with some mildly decent hip flexors and hamstrings. Tibialis anterior, gastrosoleus, and EHL are all 5/5 on the left. On the right hand side she was 5/5 throughout. She had some decreased sensation in a patchy distribution in the L3 and L4 distribution on the left when compared to the right. The patient was immediately started on IV Decadron 10 mg q.6 hours. On postop day #2 the patient had continued weakness. She was started with physical therapy for ambulation and motion. By postop day two she was getting some return function in the left lower extremity. She was able to fire her left quads, however, she did not have any function anti-gravity. Hip flexors were also improving. By postop day #4 she was gaining strength in her left quads, improving to about a 2/5, with increased movement of that left lower extremity. She continued to improve. However, I felt that it was necessary to get a rehab consult. Each day she showed steady improvement. By January 2, 2007 at the time of transfer to the acute rehab, she had approximately 2-3 strength in the left quads. Adductors improving. She had full function in all other muscle groups with return of sensation. She was able to ambulate with a walker and clear her left foot. X-rays taken showed implants and spine was in acceptable alignment without any signs of loosening or breakage of implants. Examination of her wounds showed no signs or symptoms of infection. She was discharged to rehab in stable condition and was told to follow up with me approximately two weeks after discharge from rehab.

LEONEL A. HUNT, M.D.

LAH/MEDQ/270379779 D: 01/21/2007 T: 01/21/2007 JOB#: 651525

Change History and Electronic Signatures:

Signed by HUNT, LEONEL (8807) at 1/29/2007 19:33

ORTHOPAEDIC CENTER

February 15, 2007

RE: ROGONE, M SHARON
MR#: 100129644

DR REFERRED FOLLOW-UP VISIT

DATE OF VISIT: 02/15/2007

HISTORY OF PRESENT ILLNESS: Ms. Rogone comes in today for follow-up evaluation. She is status post L2-5 extreme lateral interbody fusion with posterior instrumentation. She comes in today stating that her strength is improving. She denies any significant back pain. She states overall most her symptoms are in her left thigh, radiating pain down the left thigh which used to be numbness. She wants to know what can she do to help control since she is walking better these days and states that if it weren't for the pain in her left thigh. If she could relieve the symptoms in her left thigh, she would be doing much better at this stage.

PHYSICAL EXAMINATION:

On physical exam her strength is improving in her left quadriceps as well. She has good hip adductors and the sensation has returned to her foot. Her overall strength is improving. X-rays taken today show implants are in good position with spine in acceptable alignment. No signs of loosening or breakage.

ASSESSMENT: Lumbar degenerate scoliosis status post anterior and posterior fusion with L4.

DISCUSSION: At this point in time, I discussed Ms. Rogone that I would like to give her Lyrica 75 mg to take twice a day for her leg pain and change her medications from the hydrocodone to the Percocet 5 mg pills. She is in agreement with this plan and treatment and will follow up with me again in six weeks' time.

Leonel A. Hunt, M.D.

LAH/MEDQ/273361052 D: 02/15/2007 T: 02/16/2007 JOB#: 766219

Change History and Electronic Signatures:Signed by HUNT, LEONEL (8807) at 2/19/2007 11:16

ORTHOPAEDIC CENTER

March 15, 2007

RE: ROGONE, M SHARON
MR#: 100129644

DR REFERRED FOLLOW-UP VISIT

DATE OF VISIT: 03/15/2007

HISTORY: The patient comes in today for follow-up evaluation. She is status post lumbar fusion for scoliosis with excellent procedure with residual L4 palsy. She comes in today stating that she is improving. She is having some nerve pain in the left lower extremity secondary to this nerve injury. However, she states that it is improving and is being controlled well with the Lyrica and the Percodan.

PHYSICAL EXAMINATION:

Her strength is greatly improving in her quadriceps. It is probably a 3+/5 at this point in time. She is able to hold against gravity. Sensation is improving throughout. She has got good strength of her hip adductors as well as abductors. X-ray evaluation shows implants are in good position with spine acceptable alignment.

ASSESSMENT: Degenerative scoliosis status post fusion.

DISCUSSION: At this point in time I discussed with the patient that I think that she is doing quite well. I told her I would like her to continue physical therapy and she should follow up with me again in three months' time. I have given her a prescription today for Percodan 5/325 and she will follow up with me in three months' time.

Leonel A. Hunt, M.D.

LAH/MEDQ/276614655 D: 03/15/2007 T: 03/15/2007 JOB#: 130805

Change History and Electronic Signatures:

Signed by HUNT, LEONEL (8807) at 3/26/2007 11:44

ORTHOPAEDIC CENTER

June 07, 2007

RE: ROGONE, SHARON M
MR#: 100129644

DR REFERRED FOLLOW-UP VISIT

DATE OF VISIT: 06/07/2007

Mrs. Rogone comes in today for follow up visit. She is now six months status post anterior and posterior spinal fusion for degenerative scoliosis. She comes in today stating that she is having no back pain, no right lower extremity symptoms. She comes in today stating that she is doing very well. She is only having some mild weakness in the left thigh and at times, she has some burning sensation in the left thigh. She has cut down tremendously on her pain medication and comes in today wanting to know how much activity she can increase to.

PHYSICAL EXAMINATION:

GENERAL: On exam, her wounds are well-healed. No signs or symptoms of infection.

NEUROLOGICALLY: She had 5/5 right lower extremity, left lower extremity. Left quad is 4/5 when compared to the right with hip flexion at 3+/5 when compared to the right.

DIAGNOSTIC STUDIES: X-rays taken in the office today show the implants are in good position in the spine, acceptable alignment; showing some signs of bone fusion across the inner space.

ASSESSMENT: Degenerative scoliosis, status post fusion.

DISCUSSION: I discussed with Ms. Rogone that she is doing quite well. She should continue with physical therapy and start increasing her activities as tolerated and she can follow up with me in six months time for her one year postoperative visit.

Leonel A. Hunt, M.D.

LAH/MEDQ/286226366 D: 06/07/2007 T: 06/07/2007 JOB#: 741281

Change History and Electronic Signatures:

Signed by HUNT, LEONEL (8807) at 6/15/2007 12:54

ORTHOPAEDIC CENTER

November 01, 2007

RE: ROGONE, SHARON M
MR#: 100129644

DR REFERRED FOLLOW-UP VISIT

DATE OF VISIT: 11/01/2007

HISTORY: The patient comes in today for a followup visit. She is status post L2 to L5 XLIF with posterior fusion for lumbar degenerative scoliosis. She comes in today stating that she has no back pain. She was able to play a round of golf, 18 holes, the other day; however, she states she still gets pain at night and intermittent pain in the left lower extremity with cramping in the thigh muscle. She takes Lyrica twice a day which helps relieve her symptoms significantly.

PHYSICAL EXAMINATION:

On exam, her wounds are well healed. No signs or symptoms of infection. She has limited range of motion; however, she compensates with bending at the hips. Neurologically, her strength is pretty much 5/5 throughout with some decreased sensation in the L4 distribution on the left-hand side when compared to the right.

IMAGING STUDIES: X-rays taken do show implant in good position. Spine is in acceptable alignment.

ASSESSMENT: Lumbar degenerative scoliosis status post fusion.

DISCUSSION: At this point, I discussed with the that she is doing very well. I told her I would like for her to continue taking Lyrica. She will take 150 mg twice a day. She will go back on Naprosyn twice a day and Soma as needed for muscle spasm and follow up with me in 6 months' time for 18-month postop visit.

Leonel A. Hunt, M.D.

LAH/MEDQ/302600364 D: 11/01/2007 T: 11/02/2007 JOB#: 830760

Change History and Electronic Signatures:Signed by HUNT, LEONEL (8807) at 11/5/2007 12:26

ORTHOPAEDIC CENTER

May 29, 2008

RE: ROGONE, SHARON M
MR#: 100129644

DR REFERRED FOLLOW-UP VISIT

DATE OF VISIT: 05/29/2008

HISTORY: Ms. Ragone comes in today for follow up visit. She is now 18 months status post L2 to L5 anterior and posterior fusion. She comes in today stating that she is doing very well. She continues to get some mild cramping in her left thigh which is improving, but overall, states she is doing very well. She is doing all the activities she wants to and has been released to full activity.

PHYSICAL EXAMINATION:

On physical examination, she has got well-healed scars. Neurologically, she has got no motor deficits. She has some decreased sensation in the L4 distribution on the left when compared to the right.

ASSESSMENT: Lumbar degenerative scoliosis status post fusion.

DISCUSSION: At this point in time, I discussed with Ms. Ragone that I would like for her to continue with her regimen. She is taking one Motrin a day with one Neurontin. I told her I would like for her to take 2 Motrin p.o. t.i.d. and she is to follow up with me in 6 months' time for her 2-year postoperative visit.

Leonel A. Hunt, M.D.

LAH/MEDQ/327933514 D: 05/29/2008 T: 05/29/2008 JOB#: 690303

Change History and Electronic Signatures:Signed by HUNT, LEONEL (8807) at 6/1/2008 16:01

ORTHOPAEDIC CENTER

March 26, 2009

RE: ROGONE, SHARON M
MR#: 100129644

DR REFERRED FOLLOW-UP VISIT

DATE OF VISIT: 03/26/2009

HISTORY: Ms. Rogone comes in today for followup evaluation. She is status post L2-5 extreme lateral interbody fusion with posterior spinal fusion for lumbar degenerative scoliosis and low back pain. She comes in today stating overall she is doing fairly well. Her pain is about a 3/10. It is positional and intermittent. She gets some muscle spasms in the left thigh region but has some mild sensory deficits with some mild numbness but has full use of the left lower extremity. She gets some mild back pain as well, and she describes pain over the SI joint.

PHYSICAL EXAMINATION:

MUSCULOSKELETAL: She has significant tenderness over the right SI joint and some spasming in the quadriceps muscle on the left-hand side.

X-rays taken in the office today show what appears to be a good fusion of L2-L5.

ASSESSMENT: Right sacroiliac joint dysfunction and left lumbar radiculopathy.

DISCUSSION: At this point in time, I discussed with Ms. Rogone that I would like for her to undergo some physical therapy for that left lower extremity to help build strength in that leg. I am also sending her for a right sacroiliac joint injection, and she will follow up with me once the injection is complete.

Leonel A. Hunt, M.D.

LAH/MEDQ/365659641 D: 03/26/2009 T: 03/27/2009 JOB#: 150139

Change History and Electronic Signatures:Signed by HUNT, LEONEL (8807) at 3/29/2009 11:10

ORTHOPAEDIC CENTER

October 08, 2009

RE: ROGONE, SHARON M
MR#: 100129644

DR REFERRED FOLLOW-UP VISIT

DATE OF VISIT: 10/08/2009

HISTORY: Ms. Rogone comes in today for a follow-up visit. She comes in today after having some new left-sided low back pain. She states it started approximately 2 months ago and feels that it has been getting worse. She states it is positional but has good range of motion. It is worse in the morning. Denies any lower extremity symptoms. No other complaints.

PHYSICAL EXAMINATION:

On exam, she has some paraspinous muscle spasm and tenderness near the lumbosacral junction as well as in the left flank.

RADIOGRAPHS: X-rays taken in the office today show implants with solid fusion; however, she does have collapse of disk space height at L1-2 with degenerative disk disease with bone on bone.

ASSESSMENT: Adjacent segment degeneration, L1-2.

DISCUSSION: At this point in time, I discussed with Ms. Rogone that she does have significant degeneration above the level of her fusion; however, her pain at this stage significantly is not very severe. I told her if her symptoms worsen or continue to be bothersome and affecting her daily activities, then we will discuss extending her fusion at this stage; however, there are no plans for further surgical intervention.

Leonel A. Hunt, M.D.

LAH/MEDQ/390833693 D: 10/08/2009 T: 10/09/2009 JOB#: 818123

Change History and Electronic Signatures:Edited and signed by HUNT, LEONEL (8807) at 10/21/2009 11:54

PATIENT: ROGONE, MARY SHARON

MED REC: 100129644

CEDARS-SINAI MEDICAL CENTER

DICTATOR: DAVID GUM-TONG NG, M.D.

PREOPERATIVE HISTORY AND PHYSICAL EXAMINATION
DATE OF ADMISSION:

REFERRING PHYSICIAN: Leonel A. Hunt, M.D.

REASON FOR CONSULTATION: Preoperative evaluation.

HISTORY OF PRESENT ILLNESS: Sharon Ragone is a 67-year-old female with a history of chronic low back pain, who currently is scheduled to undergo an L1-2 extreme lateral interbody fusion on November 18, 2009. The patient states that she has had back pain for many years. In July of 2005, she underwent bilateral multilevel laminectomies, which resulted in an increase in her symptoms as well as with a lost disk space and height. She subsequently underwent a repeat back surgery in December of 2006 at which time multilevel effusions were performed. The patient did well postoperatively, however, in July of this year, she noted increasing left-sided back pain as well as left lower extremity pain. She has been evaluated by Dr. Leonel Hunt, who currently plans the L1-2 extreme lateral interbody fusion. The patient otherwise feels well. She reports no recent illnesses. No fevers, shakes, or chills. No sore throats. No cough. No shortness of breath. No chest pain. No abdominal pain. No nausea, vomiting, or diarrhea, and no urinary tract infection symptoms. The patient overall is in a normal state of health. She states that she has never had any exertional chest pain or cardiac history.

PAST MEDICAL HISTORY:

1. Hypertension.
2. Multiple PVCs.
3. A history of mild tricuspid regurgitation.
4. Chronic low back pain as noted above.

MEDICATIONS:

1. Estrace 1 mg p.o. daily.
2. Lotensin 20 mg p.o. b.i.d.

ALLERGIES: The patient states that she knows of no allergies to medications but states that she does develop some itchiness with walnuts. She also has nausea to multiple opiates including morphine, Vicodin, codeine, and Norco.

SOCIAL HISTORY: The patient is married and currently lives with her husband in Apple Valley. She is a nonsmoker. She has one glass of wine every 2 to 3 weeks. There is no history of any IV or illicit drug use. She has 3 children. She is a retired neonatal intensive care unit nurse and is now an inventor with multiple patents.

FAMILY HISTORY: Her mother is alive at the age of 88 and has dementia, congestive heart failure, and coronary artery disease. She states that her mother has suffered heart attacks in the past. Her father is also alive at the age of 89 and has sick sinus syndrome, status post pacer. He has also had multiple valve replacement surgeries.

REVIEW OF SYSTEMS:

A 10-point review of systems was conducted with the patient and is negative unless otherwise noted in the HPI.

PHYSICAL EXAMINATION:

VITAL SIGNS: The temperature is 96.8, heart rate is 72, blood pressure is 112/70, respiratory rate is 12. Weight is 152 pounds.

GENERAL: This is a well-developed, well-nourished female in no acute distress. She does appear to move gingerly. She is alert and oriented

and very pleasant.

HEENT: Oropharynx is clear. Sclerae are anicteric.

NECK: Supple.

CARDIOVASCULAR: Regular rate and rhythm with a normal S1 and S2. No murmurs, gallops, or rubs are appreciated.

LUNGS: Clear to auscultation bilaterally without any wheezes, rales, or rhonchi.

ABDOMEN: Soft, nontender, and nondistended with normoactive bowel sounds.

EXTREMITIES: Without any cyanosis, clubbing, or edema.

SKIN: No rashes.

LABORATORY DATA: The patient had an electrocardiogram performed, which demonstrates a normal sinus rhythm at a rate of 74. There appears to be a normal axis. No acute ST changes are noted.

Chest x-ray is pending.

IMPRESSION: Sharon Ragone is 67-year-old female with a history of chronic low back pain with multiple prior back surgeries, who is currently scheduled to undergo an L1-2 extreme lateral interbody fusion. This is an intermediate or moderate risk procedure. No further preoperative cardiac testing is indicated per ACC criteria. The patient, in addition, also does not appear to be acutely infected or have any history of any recent infections.

PROBLEM LIST:

1. Chronic low back pain with a disk degeneration.
2. Hypertension.

PLAN:

1. We will check routine preoperative laboratories including a CBC, BMP, PT/PTT, as well as urinalysis.
2. A chest x-ray has been ordered, which we will follow up on.
3. The patient has been instructed to avoid all aspirin and NSAID products 1 week prior to surgery.
4. I will follow up on all her preoperative laboratories and make any further recommendations as necessary.

Thank you very much for this consultation.

ADDENDUM: Labs reviewed. No further testing or therapies indicated at this time.

DAVID GUM-TONG NG, M.D.

DGN/MEDQ/395821420 D: 11/16/2009 T: 11/16/2009 JOB#: 422072

cc: Leonel A. Hunt, M.D.

Change History and Electronic Signatures:

Edited and signed by NG, DAVID (7366) at 11/17/2009 18:11

PATIENT: ROGONE, MARY SHARON

MED REC: 100129644

CEDARS-SINAI MEDICAL CENTER

DICTATOR: LEONEL A. HUNT, M.D.

OPERATION REPORT

DATE OF OPERATION: 11/18/2009

PREOPERATIVE DIAGNOSIS: L1-2 disc disease and kyphosis.

POSTOPERATIVE DIAGNOSIS: L1-2 disc disease and kyphosis.

OPERATION(S) PERFORMED:

1. L1-2 discectomy via a lateral transpsoas approach.
2. L1-2 anterior interbody fusion.
3. Correction of kyphosis deformity.
4. Placement of structural PEEK graft, 9 x 45 x 18-mm lordotic Pioneer Cross-Fuse.
5. Use of BMP.
6. Use of morselized allograft.
7. Use of intraoperative fluoroscopy and interpretation.

CO-SURGEON: Leonel A. Hunt, M.D., orthopedic surgery.

CO-SURGEON: Gabriel E. Hunt, M.D., neurosurgery.

ASSISTANT:

ANESTHESIOLOGIST: Eleonora C. Hemaya, M.D.

ANESTHESIA: General endotracheal.

BACKGROUND: The patient is a 67-year-old female with history of low back pain. She had a previous L2 to L5 fusion. She complains of back pain and lower extremity symptoms. Imaging studies showed a complete collapse of the L1-2 disc space with a scoliotic and kyphotic deformity.

OPERATIVE FINDINGS: The patient was found to have complete collapse of the L1-2 disc with kyphosis and scoliosis.

PROCEDURE SUMMARY: Once positive identification was made and informed consent was obtained the patient was brought to the operating room where she was sedated and intubated by anesthesia in a standard fashion. The patient was turned to the left side down, right side up, lateral decubitus position appropriate for the 2-incision technique for the lateral interbody fusion technique. The patient was fixed into position with axillary pads in place. Using fluoroscopy skin markers were made to identify 5 disc space levels.

At this point in time the patient was then prepped and draped in a normal sterile fashion for standard 2-incision retroperitoneal approach was used to gain access to the lumbar spine. The patient connected to neural monitoring and with use of triggered EMG and sequential free-run EMG, sequential dilators were passed through the psoas muscle docking at the L1-2 disc space. With intraoperative fluoroscopy, once found to be in good position, self-retaining retractor was placed. At this point in time, it was checked on both AP and lateral views for positioning and first stage discectomies were performed at the L1-2 disc space with preparation of the end plates. Once adequate preparation was completed and adequate discectomy was completed, the disc space was thoroughly irrigated. Trial sizers were placed and it was found that 9 x 18 x 45-mm graft with the structural PEEK graft by Pioneer was stuffed with morselized allograft and BMP. Under fluoroscopic guidance, structural PEEK graft was placed in the graft. There was correction of the scoliosis and kyphotic deformities. self-retaining retractor was removed and closure began at this

time. Throughout the procedure there were no significant changes with neural monitoring. Signals remained stable.

Deep tissues were closed #1 Vicryl suture followed by subcuticular closure of the skin with 2-0 Vicryl sutures. Steri-Strips, sterile gauze and Tegaderm was placed over the wound. Prior to closing the skin, all sponge, needle, and instrument counts were found to be correct.

The patient was extubated and transferred to the recovery room in stable condition. There were no complications during the case. The patient tolerated the procedure well.

LEONEL A. HUNT, M.D.

LAH/MEDQ/396124640 D: 11/18/2009 T: 11/19/2009 JOB#: 939727

cc: Gabriel E. Hunt, M.D.

Change History and Electronic Signatures:

Edited and signed by HUNT, LEONEL (8807) at 11/19/2009 13:34

PATIENT: ROGONE, MARY SHARON

MED REC: 100129644

CEDARS-SINAI MEDICAL CENTER

DICTATOR: GABRIEL E. HUNT, M.D.

OPERATION REPORT

DATE OF OPERATION: 11/18/2009

PREOPERATIVE DIAGNOSIS: L1-2 disk disease with kyphosis.

POSTOPERATIVE DIAGNOSIS: L1-2 disk disease with kyphosis.

OPERATION(S) PERFORMED:

1. L1-2 diskectomy via lateral transpsaos approach.
2. L1-2 anterior interbody fusion.
3. Correction of kyphotic deformity.
4. Placement of structural of PEEK graft, 9 x 45 x 18-mm lordotic Pioneer graft used.
5. Use of bone morphogenic protein.
6. Use of morselized allograft.
7. Use of intraoperative fluoroscopy interpretation.

CO-SURGEONS: Gabriel E. Hunt, M.D. (Neurosurgery).

CO-SURGEONS: Leonel A. Hunt, M.D. (Orthopedic Surgery).

ANESTHESIOLOGIST: Elenora Maya, M.D.

ANESTHESIA: General endotracheal.

BACKGROUND: The patient is a 67-year-old female with history of low back pain and a previous L2 through 5 fusion. She had complaints of back pain and lower extremity symptoms. Imaging studies showed a complete class of L1-2 disk space with scoliotic-kyphotic deformity.

OPERATIVE FINDINGS: The patient was found to have a complete class of L1-2 disk with kyphoscoliosis.

OPERATIVE PROCEDURE: The patient was brought to the operating room and intubated by anesthesia in the customary fashion. The patient was turned in the left-side down and the right-side-up lateral decubitus position, appropriate for the 2-incision technique for the lateral interbody fusion. The patient was positioned with axillary pads in place. Fluoroscopy was utilized to identify the L1-2 disk space, and skin marks were made coinciding with the correct level. At this point in time, the patient was then prepped and draped in a sterile fashion and, again, a 2 incision, retroperitoneal approach was used to gain access to the lumbar spine.

The patient was connected to the neuro monitor, and with the use of the triggered EMG and sequential free-running EMG, sequential dilators were passed through the psoas muscle, docking at the L1-2 disk space. With the intraoperative fluoroscopy, once found to be in good position, the self-retaining retractors were placed; and, at this point in time, it was checked in both AP and lateral views for positioning; and diskectomy was performed at the L1-2 disk space with preparation at the endplates.

Once adequate preparation was completed and the disk was removed, the disk space was temporarily irrigated. The trial size was replaced, and it was found that a 9 x 18 x 45-mm structural PEEK graft by Pioneer will be used. The graft was stuffed with morselized allograft and bone morphogenic protein. Under fluoroscopic guidance, the structural peak graft was placed in the interbody space. The kyphotic and scoliotic deformities were corrected, and the self-retaining retractors were then

removed, and closure was begun at this time.

Fluoroscopy was used to look at both AP and lateral views just to make sure that the graft was in the correct position, and it was found to be sufficient. Closure was begun at this time, and the deep tissues were closed with #1 Vicryl suture followed by a subcuticular closure, and the skin with a 2-0 Vicryl suture. Steri-Strips, a sterile dressing and Tegaderm were placed over the wound. All the sponge, needle and instrument counts were correct at the end of the case. The patient was extubated and transferred to the recovery room in stable condition.

GABRIEL E. HUNT, M.D.

GEH/MEDQ/396601233 D: 11/22/2009 T: 11/23/2009 JOB#: 439690

cc: Leonel A. Hunt, M.D.

Change History and Electronic Signatures:

Edited and signed by HUNT, GABRIEL (8843) at 11/23/2009 15:21

ORTHOPAEDIC CENTER

November 30, 2009

RE: ROGONE, MARY SHARON
MR#: 100129644

DR REFERRED FOLLOW-UP VISIT

DATE OF VISIT: 11/30/2009

HISTORY: Ms. Rogone comes in today for followup evaluation. She is now 10 days status post lateral fusion at L1-2. She comes in today stating that overall the back pain she had before surgery is gone. She has most significantly a left-sided thigh pain which was there prior to surgery. She states it is a little bit worse today.

PHYSICAL EXAMINATION:

On examination her wounds are healing well. No signs or symptoms of infection. Neurologically she has no significant motor or sensory deficits. X-rays taken in the office today show implants in good position. Spine is in acceptable alignment.

ASSESSMENT: Lumbar degenerative disk disease with radiculitis status post fusion.

DISCUSSION: At this point in time I discussed with Ms. Rogone that I think she is doing very well. I have told her we will continue to monitor the left leg. I would like for her to see me back in the office in 4 weeks' time. She was given a prescription today for a refill on Neurontin as well as Percocet.

Leonel A. Hunt, M.D.

LAH/MEDQ/397469994 D: 11/30/2009 T: 11/30/2009 JOB#: 460577

Change History and Electronic Signatures:

Signed by HUNT, LEONEL (8807) at 12/31/2009 11:17

ORTHOPAEDIC CENTER

January 05, 2010

RE: ROGONE, MARY SHARON
MR#: 100129644

DR REFERRED FOLLOW-UP VISIT

DATE OF VISIT: 01/05/2010

HISTORY: Ms. Rogone comes in today for a followup evaluation. She is 6 weeks status post L1-2 extreme lateral interbody fusion. She comes in today, denying any back pain. Her pain is intermittent, about a 2/10 at times. She still gets cramping in the left leg. At this stage she wants to know if she can start exercising again.

EXAM: Wounds are well healed. Neurologically, she has no motor deficits.

IMAGING STUDIES: X-rays taken in the office today show implants are in good position, spine is in acceptable alignment.

ASSESSMENT: Lumbar degenerative disease, status post fusion.

DISCUSSION: At this point in time I discussed with Ms. Rogone that I think she is doing very well and I told her she needs to continue wearing her brace. She can start using the elliptical machine and walking in the pool. She is to follow up with me in six weeks' time.

Leonel A. Hunt, M.D.

LAH/MEDQ/401808236 D: 01/05/2010 T: 01/06/2010 JOB#: 567104

Change History and Electronic Signatures:
Signed by HUNT, LEONEL (8807) at 1/8/2010 17:36

ORTHOPAEDIC CENTER

May 11, 2010

RE: ROGONE, MARY SHARON
MR#: 100129644

DR REFERRED FOLLOW-UP VISIT

DATE OF VISIT: 05/10/2010

HISTORY: MS. Rogone comes in today for followup evaluation. She is 6 months status post L1-L2 fusion. She comes in today stating that overall she has no back pain. She still has some numbness and tingling in the leg which has been chronic from her first surgery. On exam she had good range of motion of lumbar spine. Neurologically she has no motor deficits. X-rays taken show implants in good position. Spine is in good alignment.

ASSESSMENT: Lumbar degenerative disease, status post fusion.

DISCUSSION: At this point in time I discussed with Ms. Rogone that I think she is doing very well. She is to continue to increase her activity as tolerated and follow up with me in 6 months' time.

Leonel A. Hunt, M.D.

LAH/MEDQ/418437395 D: 05/11/2010 T: 05/11/2010 JOB#: 922006

Change History and Electronic Signatures:
Signed by HUNT, LEONEL (8807) at 5/23/2010 15:55

ORTHOPAEDIC CENTER

February 08, 2011

RE: ROGONE, MARY SHARON
MR#: 100129644

DR REFERRED FOLLOW-UP VISIT

DATE OF VISIT: 02/08/2011

HISTORY: Ms. Rogone comes today for a followup visit. She is status post lumbar fusion. She states the numbness and tingling in the left leg is slowly improving. At this stage she states that overall she is doing well. She is working out in the gym.

PHYSICAL EXAMINATION:

On examination, she has still has some decreased sensation in the anterolateral thigh. Otherwise no deficits.

X-RAYS: Taken today show implants are good position and spine is in acceptable alignment.

ASSESSMENT: Lumbar degenerative disk disease status post fusion.

DISCUSSION: At this point in time I discussed with Ms. Rogone I think she is doing very well. She is to continue increasing activities as tolerated. Follow up with me in 1 year.

Leonel A. Hunt, M.D.

LAH/MEDQ/453195510 D: 02/08/2011 T: 02/09/2011 JOB#: 710833

Change History and Electronic Signatures:

Signed by HUNT, LEONEL (8807) at 2/14/2011 14:26

ORTHOPAEDIC CENTER

May 31, 2011

RE: ROGONE, MARY SHARON
MR#: 100129644

DR REFERRED FOLLOW-UP VISIT

DATE OF VISIT: 05/31/2011

HISTORY: Ms. Rogone comes in today for follow-up evaluation. She continues to have some spasms in the left thigh, they come intermittently, recently had EMG, which shows a left femoral neuropathy.

PHYSICAL EXAMINATION:

On exam, she does have some spasms in the quadriceps muscle on the left side when compared to the right. Otherwise, neurologically no deficits.

ASSESSMENT: Muscle spasms, possible myofascial pain syndrome.

DISCUSSION: At this point in time, she states that she would like to be evaluated for the possibility of trigger point versus Botox injections in the painful spastic muscles. I am referring her to Dr. Jerry Pryde for evaluation, and then she will follow up with me once the consult is completed.

Leonel A. Hunt, M.D.

LAH/MEDQ/468110549 D: 05/31/2011 T: 05/31/2011 JOB#: 615801

Change History and Electronic Signatures:

Signed by HUNT, LEONEL (8807) at 6/1/2011 18:41

Notes on the Report Format: + = New Result Since Last Cumulative Report
R = Actual Receive Time (Otherwise Collection Time)
* = Abnormal Result

□

D E P A R T M E N T O F P A T H O L O G Y

A N D

L A B O R A T O R Y M E D I C I N E

CUMULATIVE REPORT FOR:

ROGONE, MARY SHARON

29101207046/100129644

DISCHARGED: 11/19/2009

IF THERE IS A DISCHARGE DATE PRINTED ABOVE, THIS IS THE FINAL CUM REPORT
FOR THIS ACCOUNT. OTHERWISE, THIS IS AN INTERIM CUM REPORT WHICH MAY BE
UPDATED.

LOCATION:

EIGHT NORTH EAST

DATE:

11/21/2009

TIME:

01:36

CEDARS-SINAI MEDICAL IMAGING GROUP (310) 423-8000
OUTPATIENT RADIOLOGY REPORT

Verified

Ordering Physician:	MRN #:	Patient Name:
LEONEL HUNT, M.D.	100129644	ROGONE, MARY

QuadRIS Order #:	Location:	Date of Birth:
8047446	8NE-8011-01	08/08/1942

ROGONE, MARY SHARON	MRN#: 100129644
ORDER#: 8047446	

LUMBAR SPINE SERIES, 2 VIEWS 02/08/2011 AT 11:48 A.M.

FINDINGS: Laminectomy changes at the L3-4 and L4-5 levels are present. Pedicle screws at the L2, L3, L4 and L5 levels bilaterally. Vertical connector rods are in place. There is no change in alignment of the pedicle screws or rods since the previous study of 05/10/2010. Interbody fusion body fusion plugs at L1-2, L2-3, L3-4, and L4-5 levels are in place. These are unchanged in the interval.

CONCLUSION: Stable interval exam since 05/10/2010.

JT:MEDQ/453211488 D: 02/08/2011 14:21:20 T: 02/08/2011 14:35:03
JOB#: 715335

Reviewed and Interpreted by:

E. JAMES TOURJE, MD / ,
Imaging Physician

Electronically verified by: E. JAMES TOURJE, MD

CSN#

29110464656
Result ID: 4375735

□

CEDARS-SINAI MEDICAL CENTER
DEPT OF PATHOLOGY AND LAB MEDICINE * 8700 BEVERLY BLVD
LOS ANGELES, CA 90048 * MAHUL B. AMIN, M.D., DIRECTOR

NAME: ROGONE, MARY SHARON AGE : 67Y SEX: F
MRN: 100129644 LOC: 8NE ROOM: 8011-01
ACCT: 29101207046 DR : HUNT, LEONEL A ADMIT DATE: 11/18/2009

===== BONE TISSUES ISSUED =====

COMPONENT TYPE	UNIT NUMBER	STATUS
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11/18/2009

+R1208 CANCELLOUS CHIPS

RT0350901846104 ISSUED, FINAL

MARY SHARON ROGONE
INPATIENT MEDICAL RECORDS COPY

MRN: 100129644
LOC: 8NE RM: 8011-01

Notes on the Report Format: + = New Result Since Last Cumulative Report
R = Actual Receive Time (Otherwise Collection Time)
* = Abnormal Result

Confidentiality Warning: The information in this system should only be viewed by patient care personnel with a "need to know" for purposes of diagnosis and treatment. All accesses are logged with your name, the patient's name, the type of data viewed, the date and time. Inappropriate accesses are subject to disciplinary measures and/or legal action, up to and including termination of employment on the first offense. Any printouts from this system should be disposed of properly.

Printed By: RIVERAK

Print Date/Time: 12:17 6/21/2011

Notes on the Report Format: + = New Result Since Last Cumulative Report
R = Actual Receive Time (Otherwise Collection Time)

* = Abnormal Result

□

D E P A R T M E N T O F P A T H O L O G Y

A N D

L A B O R A T O R Y M E D I C I N E

CUMULATIVE REPORT FOR:

ROGONE, M SHARON

10101059119/100129644

DISCHARGED: 01/04/2007

IF THERE IS A DISCHARGE DATE PRINTED ABOVE, THIS IS THE FINAL CUM REPORT
FOR THIS ACCOUNT. OTHERWISE, THIS IS AN INTERIM CUM REPORT WHICH MAY BE
UPDATED.

LOCATION:

SEVEN SOUTH EAST

DATE:

01/05/2007

TIME:

05:38

□

CEDARS-SINAI MEDICAL CENTER
DEPT OF PATHOLOGY AND LAB MEDICINE * 8700 BEVERLY BLVD
LOS ANGELES, CA 90048 * MAHUL B. AMIN, M.D., DIRECTOR

NAME: ROGONE, M SHARON	AGE : 64Y	SEX: F
MRN: 100129644	LOC: 7SE	ROOM: 7908-01
ACCT: 10101059119	DR : RIGGS, RICHARD V	ADMIT DATE: 01/02/2007

```

===== BLOOD CHEMISTRIES =====
TEST:      NA      K      CL      CO2      AGAP      BUN      CREAT  GLUCOSE
UNITS:      MMOL/L  MMOL/L  MMOL/L  MMOL/L  MMOL/L  MG/DL   MG/DL   MG/DL
LO-HI:     135-145  3.5-5.0  101-111  23-31           5-25   0.4-1.5  70-110
-----
01/03/07
0645      *134      4.9      *97      28      9      25      0.7      *147

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===== BLOOD CHEMISTRIES =====
TEST:      URIC
          ACID    CALCIUM    PHOS      MG      OSMOL
UNITS:      MG/DL    MG/DL    MG/DL    MG/DL  MOSM/KG
LO-HI:      2.0-8.0  8.3-10.7  2.5-5.0  1.6-2.6  275-295
-----
01/03/07
0645              8.9

```

M SHARON ROGONE
INPATIENT MEDICAL RECORDS COPY

MRN: 100129644
LOC: 7SE RM: 7908-01

□

CEDARS-SINAI MEDICAL CENTER
DEPT OF PATHOLOGY AND LAB MEDICINE * 8700 BEVERLY BLVD
LOS ANGELES, CA 90048 * MAHUL B. AMIN, M.D., DIRECTOR

NAME: ROGONE, M SHARON AGE : 64Y SEX: F
MRN: 100129644 LOC: 7SE ROOM: 7908-01
ACCT: 10101059119 DR : RIGGS, RICHARD V ADMIT DATE: 01/02/2007

===== BLOOD COUNT =====
TEST: WBC RBC HGB HCT MCV MCH MCHC
UNITS: 1000/UL MILL/UL G/DL % FL PG %
LO-HI: 4-11 3.67-5.11 11.6-15.4 34.3-45.4 80-100 27-33 32-36

01/03/07
0645 8.9 3.71 11.9 35.1 94.6 32.1 33.9

===== BLOOD COUNT =====
TEST: PLATELETS PLATELET PLATELETS MEAN PLATELET
AUTOMATED DENSITY VERIFIED VOLUME
UNITS: /UL /UL FL
LO-HI: 150000-450000 150000-450000 7.4-10.4

01/03/07
0645 348000 *7.2

===== DIFFERENTIAL CELL COUNT =====
TEST: DIFF <----POLYS----> <----BANDS----> <----LYMPHS---->
UNITS: % 1000/UL % 1000/UL % 1000/UL
LO-HI: 1.8-8.0 <11 <0.85 1.0-4.5

01/03/07
0645 AUTO 87 7.8 7 *0.6

===== DIFFERENTIAL CELL COUNT =====
TEST: <----MONOS----> <----EOS----> <----BASOS---->
UNITS: % 1000/UL % 1000/UL % 1000/UL
LO-HI: <0.8 <0.4 <0.2

01/03/07
0645 5 0.5 0 0.0 0 0.0

===== CELL MORPHOLOGY, AUTOMATED =====
TEST: RBC DISTRIB
WIDTH
UNITS: %
LO-HI: 11.5-14.5

01/03/07
0645 12.3

CONTINUED

CONT:

PAGE: 3
M SHARON ROGONE
INPATIENT MEDICAL RECORDS COPY

MRN: 100129644
LOC: 7SE RM: 7908-01

NAME: ROGONE, M SHARON	AGE : 64Y	SEX: F
MRN: 100129644	LOC: 7SE	ROOM: 7908-01
ACCT: 10101059119	DR : RIGGS, RICHARD V	ADMIT DATE: 01/02/2007

TEST:	CELL MORPHOLOGY		
	RBC	WBC	PLATELET
01/03/07			
0645	NORMAL		

CONT:

PAGE: 4
M SHARON ROGONE MRN: 100129644
INPATIENT MEDICAL RECORDS COPY LOC: 7SE RM: 7908-01

<https://cscdrweb.csmc.edu/cdr/result10.asp?ptid=1694570&rhid=213506442&printme=y...> 6/21/2011

LOS ANGELES, CA 90048 * MAHUL B. AMIN, M.D., DIRECTOR

NAME: ROGONE, M SHARON

AGE : 64Y SEX: F

MRN: 100129644

LOC: 7SE

ROOM: 7908-01

ACCT: 10101059119

DR : RIGGS, RICHARD V

ADMIT DATE: 01/02/2007

===== POINT OF CARE TESTING =====

TEST: *GLUCOMETER*

UNITS: MG/DL

LO-HI: 70-110

01/02/07

2326 *176

01/03/07

0635 *143

+ 1738 *147

01/04/07

+ 0641 *130

END OF REPORT

END OF

PAGE: 5

M SHARON ROGONE

INPATIENT MEDICAL RECORDS COPY

MRN: 100129644

LOC: 7SE

RM: 7908-01

Notes on the Report Format: + = New Result Since Last Cumulative Report
R = Actual Receive Time (Otherwise Collection Time)

* = Abnormal Result

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INTRAOPERATIVE MONITORING REPORT

PATIENT NAME: Rogone, Mary Sharon

MRN #: 100129644

PROCEDURE DATE: 11/18/09

REFERRING PHYSICIAN: Leonel A. Hunt, MD

Interpretation of Baseline Recordings: Bilateral posterior tibial, peroneal and ulnar from the left-sided stimulations SSEP cortical peak latencies were mildly delayed, which may have been at least partially due to the presence of anesthetics. The ulnar from the right-sided stimulations SSEP cerebral peaks were normal. Bilateral L2 dermatomal SSEPs were present. Because dermatomal SSEPs are somewhat variable, this lab mainly considers dermatomal SSEPs normal if present and abnormal if absent.

Clinical Interpretation of Intraoperative Monitoring: No significant changes in SSEPs were detected during the monitoring of this operation. With regard to monitoring of the spinal cord, SSEPs mainly assess posterior column function, so abnormalities of the anterior and/or lateral columns could potentially not be detected with this type of test. Free-run EMG recording from various lower extremity muscles and triggered stimulation were also provided in order to help identify various neural elements, and the OR physicians were promptly made aware of any spontaneous discharges suggesting irritation of the relevant nerves.

☐ Significant Data Change
☐ No Data Change From Baseline

☒ Insignificant Data Change
☐ Unable to Assess Data / Poor
Replication of Waveforms

Lilit Mnatsakanyan, M.D.

Physician ID: 12095

Neurophysiology Fellow

Dr. Tsimerinov has interpreted the patient's entire study, with his physical presence, guidance and interpretation of key parts of the procedure.

(Interpretation of the baseline recording and intraoperative monitoring data were reviewed in real time and performed in accordance to the Medical Center guidelines. I directly reviewed or have supervised interpretation of the baseline recording and intraoperative provision of the neurophysiological data while being present either in the operating room during the surgical procedure or at remote location on the Medical Center premises utilizing the closed circuit television or digital transmission. I have solely been involved in the neurophysiological service provided during the discussed of the above intraoperative monitoring).

Eugene Tsimerinov, M.D.

Physician ID: 9798

Clinical Neurophysiology Attending

Nerve Conduction & EMG Report

Patient: Mary Rogone **Age:** 68 Years 9 Months
Patient ID: 100129644 **Ref. M.D.:** Dr. Hunt
Sex: Female **Exam M.D.:** Dr. Berkley
Date of Birth: 8/8/1942

Sensory NCS

Nerve / Sites	Rec. Site	Onset Lat ms	Peak Lat ms	NP Amp μV	PP Amp μV	Segments	Distance cm	Velocity m/s
L SURAL - Lat Mall Antidr								
Calf	Lat Mall	2.30	3.10	15.3	19.0	Calf - Lat Mall	14	60.9
R SURAL - Lat Mall Antidr								
Calf	Lat Mall	2.10	3.00	17.2	22.6	Calf - Lat Mall	14	66.7
L SUP PERONEAL - Ankle Antidr								
Lat Leg	Ankle	1.70	2.40	11.4	14.9	Lat Leg - Ankle	12	70.6
R SUP PERONEAL - Ankle Antidr								
Lat Leg	Ankle	1.80	2.45	19.4	10.5	Lat Leg - Ankle	12	66.7

Motor NCS

Nerve / Sites	Rec. Site	Lat ms	Amp mV	Seq Amp %	Segments	Dist cm	Velocity m/s
L COMM PERONEAL - EDB							
Ankle	EDB	4.60	2.2	100	Ankle - EDB	7	
Fib Head	EDB	10.30	2.2	100	Fib Head - Ankle	27	47.4
Knee	EDB	12.60	2.1	95.9	Knee - Fib Head	10	43.5
R COMM PERONEAL - EDB							
Ankle	EDB	5.45	2.2	100	Ankle - EDB	7	
Fib Head	EDB	11.00	2.2	97.5	Fib Head - Ankle	27	48.6
Knee	EDB	13.25	2.2	101	Knee - Fib Head	10	44.4
L TIBIAL (KNEE) - AH							
Ankle	AH	5.10	8.1	100	Ankle - AH	7	
Knee	AH	13.10	4.9	59.7	Knee - Ankle	36	45.0
R TIBIAL (KNEE) - AH							
Ankle	AH	4.85	9.3	100	Ankle - AH	7	
Knee	AH	12.80	5.5	59.4	Knee - Ankle	37	46.5

Motor NCS

Nerve / Sites	Rec. Site	Lat ms	Amp mV	Seq Amp %	Segments
L FEMORAL - Vastus					
A.Ing.Lig	Vastus	5.85	1.0	100	A.Ing.Lig - Vastus
R FEMORAL - Vastus					
A.Ing.Lig	Vastus	5.05	3.6	100	A.Ing.Lig - Vastus

F Wave

Nerve	Fmin ms
L COMM PERONEAL	49.65
R COMM PERONEAL	54.30

H Reflex

Nerve	H Lat ms
L TIBIAL (KNEE) - Soleus (S1)	37.10
R TIBIAL (KNEE) - Soleus (S1)	37.50

EMG Summary Table									
	Spontaneous					MUAP			Recruitment
	LA	Fib	PSW	Fasc	H.F.	Amp	Dur.	PPP	Pattern
L. VAST LATERALIS	N	None	None	None	None	N	N	N	N
L. VAST MEDIALIS	N	None	None	None	None	N	N	N	N
L. TIB ANTERIOR	N	None	None	None	None	N	N	N	N
L. PERON LONGUS	N	None	None	None	None	N	N	N	N
L. GASTROCN (MED)	N	None	None	None	None	N	N	N	N
L. ILIOPSOAS	N	None	None	None	None	N	N	N	N
R. VAST LATERALIS	N	None	None	None	None	N	N	N	N
R. VAST MEDIALIS	N	None	None	None	None	N	N	N	N

FINDINGS:

- 1) There was a significant discrepancy with the left Femoral motor nerve amplitude vs. the right. The left was 1mV as compared to the right at 3.6mV.
- 2) Normal nerve conduction otherwise.
- 3) Normal EMG needle exam.

IMPRESSION:

- 1) **There appears to be electrodiagnostic evidence of a left femoral neuropathy.** The EMG needle exam was normal with the exception of some effort based lack of recruitment, but when compared to the right, this appears normal.
- 2) No evidence of lumbar radiculopathy.

Jason Berkley, DO

